STATE TITLE V BLOCK GRANT NARRATIVE
STATE: WV
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications are located at the following address:

Office of Maternal, Child and Family Health
Room 427
350 Capitol Street
Charleston, WV 25301

Contact: Kathy Cummons, Director
Research, Evaluation and Planning Division
Telephone: (304)-558-7171
email kathycummons@wvdhhr.org

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The West Virginia Title V Block Grant Application was distributed for public comment as follows: 1) Newspaper ads were run in select papers, announcing the availability of the above documents in draft format at the local Department of Health and Human Resources office in each county seat and at the public library. 2)Five public meetings were held in April and May to secure public input in Parkersburg, Martinsburg, Beckley, Fairmont and Charleston. 3) Copies of the draft, including a public comment form, were also sent to the following: Developmental Disabilities Council, WVU Affiliated Center for Developmental Disabilities, UAP, Social Services (Responsible for IV-B/IV-E, etc.), Office of Behavioral Health Services, Medical Advisory Chairs: Department of OB/GYN - WVU, Department of Pediatrics - Marshall University and Department of Community Medicine - WVU, Governor's Cabinet on Children and Families, West Virginia Chapter March of Dimes, Family Voices - West Virginia, Interagency Coordinating Council Chair (Part C/IDEA), West Virginia Commission for Deaf and Hard of Hearing, West Virginia Department of Education: Office of Health Schools, Special Education.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

West Virginia is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving West Virginia the highest elevation of any state east of the Mississippi River. The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 more than 75% rural. Even so, West Virginia is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with Interstate 79 providing access to Charleston, WV, our state capitol. Winding secondary roads connect the majority of the state's population, with little to no public transportation available between many of the small, isolated towns. Therein lies the single most often cited issue with access to health care for many of the state's residents.

Thirty-seven of West Virginia's 55 counties are classified as being medically underserved areas with an additional 12 counties classified as partially underserved. According to the West Virginia Office of Epidemiology and Health Promotion Bureau for Public Health, Department of Health and Human Resources, the current number of licensed physicians in WV was 4,067 as of September 28, 2004. Of these, 3,515 (86%) were licensed Medical Doctors and 522 (14%) were licensed Osteopathic Physicians. The unequal distribution of professional health care manpower, particularly in rural areas, is problematic for the state. As of September 2004, forty of West Virginia's fifty-five counties (73 percent) were fully or partially designated by the federal government as Health Professional Shortage Areas. This designation means that the ratio of primary care physicians to the total population is less than 1:3500.

Eight-one (81) primary care centers are located in the forty-nine (49) counties federally designated in whole or in part as a Medically Underserved Area or Medically Underserved Populations (MCUAs/MUPs), thus making them eligible for federal assistance. There are fourteen (14) free clinics, otherwise known as Health Rights, eleven (11) of which are state funded. They offer care to uninsured West Virginians whose income is at or below 150% of the federal poverty level (FLP). These free clinics receive no federal funding. The primary care centers serve as the principal sources of primary medical services in the rural Medically Underserved Areas of West Virginia, and they are often the only source of medical care in many isolated rural communities.

Primary care centers, supported with state or federal funds, must see all patients regardless of their ability to pay. Beginning in FY 1982-83, the state began funding primary care centers through competitive applications to help centers survive financial difficulty associated with their provision of uncompensated care. State funding of primary car centers has curtailed closures and allowed some centers in financial difficulty to remain open.

In mid-March, West Virginia passed legislation intended to enable more small businesses to provide coverage to their employees. The State Coverage Initiatives (SCI) program helped to make the proposed expansion possible by providing the state with a $1.36 million demonstration grant in 2003; the grant was intended to support the design and implementation of a new coverage program.

The new law creates a public/private partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies. The private carriers will be given access to PEIA's reimbursement rates, enabling them to sell coverage that is more affordable than they have been able to sell previously. In fact, the state expects the new small business coverage cost to be 20-25 percent below the usual market rate -- which will ultimately expand the pool of insured working West Virginians.

During the fall, the West Virginia Health Care Authority reached out to health care providers and

insurance carriers to solicit participation in the program. The new coverage plan will be open to small businesses with 2 to 50 employees who have had no coverage for 12 consecutive months. Employers will be required to pay a minimum of 50 percent of the premium cost for employee-only coverage and 75 percent of eligible employees must participate. Participating carriers must demonstrate a minimum anticipated medical loss ratio of 77 percent to be eligible for a rate increase after the first year of the plan (the current requirement is 73 percent). As of December 2004, one carrier has filed with the state to offer the new product which was available January 1, 2005.

According to the 2003 Data, Census Population, March 2004 Survey of the US Census Bureau, WV ranks 34 in lacking health insurance with 16.6% of the population not having health insurance.

West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from U.S. census show West Virginia among the most racially homogeneous states in the country. The 2000 census reported that 95.9% of WV residents are Caucasian, 3.5% Black or African American, .6% American Indian and Alaska Native, 0.7% Asian and 0.3 some other race. The ancestry of the state's population is primarily a combination of Irish and Celtic followed by a broad mixture from other European countries.

West Virginia now has the distinction of having the oldest median age in the nation (38.1 years). West Virginia has the highest median age in the nation at 38.9, and the state's percent of people age 60 and older is ranked second in the nation. Between 1990 and 2000 people 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41. 3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 20,000 births in 2001 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease, having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend has continued through 2003. Because of its older population, West Virginia ranked 1st among the states in 1998 in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain the highest percent of home ownership in the nation at 75.15%. Almost 85% of individuals age 65 and older own their home.

Over the past 30 years the dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are often part-time and do not include insurance plans. The low wages earned at such jobs often do not allow individuals to purchase their own health insurance coverage.

West Virginia's annual average total nonfarm payroll employment increased by 8,600 jobs during 2004. The majority of this job growth occurred among the service providing industries, particularly educational and health services and leisure and hospitality firms. Goods producing industries made progress in total mining and construction, although statewide manufacturing continued to decline.

According to the West Virginia Bureau of Employment Programs, West Virginia's annual average unemployment rate declined seven-tenths of a percentage point during 2004 to 5.3% of the civilian labor force. The annual average number of jobless returned to pre-recession levels, dropping by some 6,000 persons to a benchmark of 42,000 unemployed. The West Virginia annual average unemployment rate has recently closed the gap entirely with the corresponding US rate. During 2004, the West Virginia rate improved to the point of dipping below the US figure by two-tenths of a percentage point. However, the decrease in the West Virginia rate reflects a declining civilian labor

force.

Also work disability is a significant problem in West Virginia. The US Census Bureau states in 2000, 22.5% of the population 16-64 years of age had a disability, and 13.2% had a work disability.

Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau and reported in the State Rankings 2002 (published by Morgan Quitno), in 2002 West Virginia continued to rank fifth in the nation at 17.2% of state's residents living in poverty, compared to the national average of 12.4%. In 2000 the median household income in West Virginia was $36,484. Of residents age 65 and older, 11.9% are living below the poverty level, while 16.0% of children age 18 and under are living in poverty. The percent of high school graduates or higher, of the population 25 years and over is 75.2%.

The Office of Maternal, Child and Family Health operates in partnership with the federal government and the State's medical community, including private practicing physicians, county health departments, community health centers , hospitals and various community agencies to address West Virginia residents' needs.

The Office of Maternal, Child and Family Health strives to provide the necessary education and access to treatment needed in order for our residents to make informed decisions regarding their own individual health needs. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's energy being used to develop systems for the provision of population-based and target specific preventive interventions, as well as infrastructure for the support of the maternal, child and family health populations.

Availability of services for West Virginia's MCFH population has increased dramatically, however, there remain areas of the State that continue to lack medical practitioners. In addition, meeting the needs of chronic or disabled populations is impaired by the lack of medical sub-specialty providers, such as occupational therapists, physical therapists, speech pathologists, dentists; and as is typical with most states, pediatric sub-specialties are mostly available at tertiary care sites. To attend to these problems, the Bureau for Public Health, in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, dentists and other specialty providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care.

In 2002, The American College of Obstetricians and Gynecologists (ACOG) named West Virginia as one of nine "Red Alert" states with a looming crisis in the availability of obstetrical care, due to physicians' problems in finding or affording medical liability insurance in the state. Without liability insurance, ob-gyns are forced to stop delivering babies, curtail surgical services, or close their doors--aggravating conditions in a state that already has many medically underserved areas. Information from ACOG surveys showed that without liability reform over half of all ob-gyn residents planned to leave West Virginia as did a majority of private practice ob-gyns. ACOG also reported problems in recruiting new ob-gyns to the state. On March 19,2003 ACOG applauded West Virginia lawmakers for their enactment of HB 2122, legislation to address the state's chronic medical liability insurance problems.

Additonal legislation includes; West Virginia House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the State's perinatal program called Right From The Start. The passage of the West Virginia Birth Score, in this same legislation, further strengthened the State's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original birth score instrument was modified to accommodate hearing screening, so one instrument and one

tracking system addresses the mandate. All WV birthing facilities began universal newborn hearing screening effective July 1, 2000. The MCFH Provider Education unit (nurses) visited the State's birthing facilities and offered technical assistance related to operationalizing the initiative.

In 2002, three additional Bills were passed, SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts. The Birth Defects Surveillance Program and the Childhood Lead Screening Program are largely supported by grants from the Centers for Disease Control (CDC). Rules for The Birth Defects Surveillance Program and The Childhood Lead Poisoning Prevention Program were passed by the 2004 Legislature.

Population

For the seventh year in a row, more state residents died than were born. In 2003, 313 West Virginians were lost to the total population as a result of natural decrease, the excess of deaths over births. The rate of natural decrease was 0.2 persons per 1,000 population. Results from the 2003 Census estimate show an overall increase (approximately 0.1%) in the state's population since 2000, from 1,808,344 to 1,810,354. This increase is the result of a slilght growth in the excess of inmigration over outmigration during that span.

Live Births

West Virginia resident live births increased by 261, from 20,725 in 2002 to 20,986 in 2003. The 2003 birth rate of 11.6 per 1,000 population also rose from 11.5 in 2002. The U.S. 2003 birth rate was 14.1 live births per 1,000 population, higher than 2002 (13.9). West Virginia's birth rate has been below the national rate since 1980. It has continued its overall decline, interrupted by slight upturns in 1989 through 1991, 1999, 2002, and 2003.

The 2003 U.S. fertility rate of 66.1 live births per 1,000 women aged 15-44 was 2.0% higher than the 2002 rate (64.8). West Virginia's fertility rate, however, increased 0.9% from 55.6 in 2002 to 56.1 in 2003. The fertility rate among women aged 15-19 in West Virginia was 0.2% lower than that among young women in the U.S. (41.6 vs. 41.7). The fertility rate among women aged 20-44 was also lower (16.7%) in the state than in the nation (58.7 vs. 70.5).

The number of births to teenage mothers decreased by 70 (2.6%), from 2,646 in 2002 to 2,576 in 2003. The percentage of total births represented by teenage births decreased from 12.8% in 2002 to 12.3% in 2003. The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than is found nationally (10.3% in 2003).

The percentage of births occurring out of wedlock rose from 2002. In 2003, over one out of every three (34.4%) West Virginia resident births was to an unwed mother. The percentages of white and black births that occurred out of wedlock in West Virginia in 2003 were 33.1% and 75.4%, respectively, compared to 31.6% and 72.1% in 2002. In the United States in 2003, 23.5% of white births (non-Hispanic) and 68.5% of births to black mothers (non-Hispanic) occurred out of wedlock. The percentage of teenage births to unmarried teenage mothers in the state noticeably increased from 71.4% in 2002 to 76.1% in 2003.

There were a total of 1,814 low birthweight babies (those weighing less than 2,500 grams or 51/2 pounds) born to West Virginia residents in 2003, or 8.7% of all births. Of the 1,797 low birthweight infants with known gestational age, 1,253 or 69.7% were preterm babies born before 37 weeks of gestation. (Of all 2003 resident births with a known gestational age, 11.7% were preterm babies.) Of the births with known birthweight, 11.9% of babies born to black mothers and 8.5% of babies born to white mothers were low birthweight. Nationally, 7.9% of all infants weighed less than 2,500 grams at birth in 2003; 7.0% of white infants and 13.5% of black infants were of low birthweight.

Eighty-six percent (85.8%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 84.3% of mothers nationwide in 2003. Among those with known prenatal care, 86.3% of the white mothers began care during the first trimester with 73.4% of black mothers seeking first trimester care. (U.S. figures show 85.5% of white mothers and 76.1% of black mothers.) No prenatal care was received by 0.6% of white mothers and by 1.2% of black mothers.

Over one-fourth (26.2%) of the 20,986 births in 2003 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol. National figures show that 11.0% of women giving birth reported smoking during pregnancy and 0.8% used alcohol. Of the state mothers who reported smoking during pregnancy, 13.3% of the babies born were low birthweight, compared to 7.0% for non-smoking mothers. U.S. statistics for 2002 show 12.2% births to smoking mothers were low birthweight and 7.5% for non-smoking mothers. Over thirty percent (31.7%) of 2003 state births were delivered by Cesarean section, compared to a national rate of 27.6%. One or more complications of labor and/or delivery were reported for 32.8% of deliveries in the State in 2003.

Deaths

Effective in 1999, the National Center for Health Statistics (NCHS) and World Health Organization (WHO) adopted the 10th revision to the International Classification of Diseases -- now known as ICD-10. This is the first revision since 1979 and includes a more comprehensive classification of causes of death. Previously, all causes of death were coded numerically. Now all causes of death are coded alpha-numerically, allowing many more possible causes. When comparing 1999 deaths to earlier years, differences between ICD-9 coding and ICD-10 coding must be taken into account.

The number of West Virginia resident deaths increased by 300, from 20,999 in 2002 to 21,299 in 2003. The state's crude death rate also rose from 11.7 per 1,000 population in 2002 to 11.8 in 2003. The average age at death for West Virginians was 72.8 (69.0 for men and 76.3 for women). One hundred and fifty West Virginia residents who died in 2003 were age 100 or older. The oldest woman was 108 years old at the time of death, while the oldest man was 105 years old.

Heart disease, cancer, chronic lower respiratory diseases, and stroke, the four leading causes of death, accounted for 63.2% of West Virginia resident deaths in 2003. Compared to 2002, the number of state deaths due to heart disease decreased 0.1% while cancer deaths decreased 0.4%. Deaths due to chronic lower respiratory diseases, which surpassed stroke for the fourth time in the past five years, increased 6.5%, while stroke mortality increased 4.9%. Diabetes mellitus deaths decreased 5.9%, while the number of reported deaths due to pneumonia and influenza increased substantially (30.2%) from 2002 to 2003. Alzheimer's disease, now the seventh leading cause of death in the Mountain State, increased 14.9%. Accident mortality increased by 19 (2.0%), from 947 in 2002 to 966 in 2003. Motor vehicle accident deaths continued to number fewer than the 435 deaths in 1993, the year the West Virginia seatbelt law took effect; they decreased by 20 (4.9%) from 412 in 2002 to 392 in 2003. Accidental poisoning deaths increased substantially (61.5%), from 156 in 2002 to 252 in 2003.

Accidents were the leading cause of death for ages one through 44 years. Even with the precipitous drop in motor vehicle accident deaths between 1993 and 1994, such fatalities remained the single leading cause of death for young adults aged 15 through 34, accounting for 26.2% of all deaths for this age group in 2003, compared with 27.7% in 2002. West Virginia's 2003 motor vehicle fatalities included four children under five years of age, compared to three in 2002.

Suicides increased by only one (277 to 278, or 0.4%) between 2002 and 2003. Male suicides decreased 1.7%, from 238 in 2002 to 234 in 2003; the number of female suicides (44) increased by five or 12.8% from 2002. Over seventy percent (71.2%) of all suicide deaths were firearm related - 74.4% of male suicides and 54.5% of female suicides. The average age of death for a suicide victim in 2003 was 47.3 years. While suicide was the 11th leading cause of death overall, it was still the

second leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under reduced from 22 in 2002 to 12 in 2003.

Homicides in West Virginia decreased by 6, from 98 in 2002 to 92 in 2003. Sixty-three (63) of the homicide victims were male, 29 were female. The average age at death for a homicide victim in 2003 was 39.1 years. There were four homicide victims under the age of five in 2003, compared to six in 2002. Over two-thirds (68.5%) of 2003 homicide deaths were due to firearms.

Years of Potential Life Lost (YPLL)

YPLL is a measure of mortality, calculated as the difference between age 75 (an average life span) and the age at death. Using YPLL before age 75, the sum of YPLL across all causes of death represents the total YPLL for all persons dying before the age of 75. A person dying at the age of 45 would therefore contribute 30 years to the total YPLL (75-45=30). YPLL is an important tool in emphasizing and evaluating causes of premature death.

The YPLL from all causes decreased 0.7%, from 162,798 YPLL in 2002 to 161,585 in 2003. The four leading causes of YPLL in 2003 were malignant neoplasms (36,000 YPLL), diseases of the heart (28,993 YPLL), non-motor vehicle accidents (14,613 YPLL), and motor vehicle accidents (13,066 YPLL). Combined, these four causes accounted for over half (57.4%) of all years of potential life lost in 2003. In comparison to 2002, YPLL attributable to malignant neoplasms increased from 21.5% of the total to 22.3%. YPLL due to diseases of the heart also increased from 17.2% to 17.9%, and YPLL due to non-motor vehicle accidents increased from 7.7% to 9.0%. The percentage of total YPLL due to motor vehicle crashes decreased, from 8.7% to 8.1%.

Infant Deaths

Deaths of infants under one year of age dropped substantially by 35, from 188 in 2002 to 153 in 2003. West Virginia's infant mortality rate also decreased, from 9.1 per 1,000 live births in 2002 to 7.3. The U.S. preliminary 2003 infant mortality rate was 6.9, same as 2002.

The state's 2003 white infant mortality rate decreased 18.8%, from 8.5 in 2002 to 6.9, while the rate for black infants decreased even more (29.8%), from 28.2 to 19.8.

Approximately one in nine (11.8%) infant deaths in 2003 was due to SIDS (sudden infant death syndrome). Twenty-four percent (23.5%) were the result of congenital malformations, while 44.4% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (7.2%).

Neonatal/Postneonatal Deaths

The number of neonatal deaths dropped by 14, from 109 in 2002 to 95 in 2003; the neonatal death rate also decreased from 5.3 deaths among infants under 28 days per 1,000 live births in 2002 to 4.5 in 2003. Neonatal deaths comprised 62.1% of all West Virginia resident infant deaths in 2003, compared to 58.0% in 2002. The rate of postneonatal deaths increased from 3.8 deaths per 1,000 neonatal survivors in 2002 to 2.8 in 2003. The 2003 U.S. neonatal death rate was 4.7, while the postneonatal rate was 2.2 deaths per 1,000 neonatal survivors.

Fetal Deaths

The 129 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2003 were 11 fewer than 2002 (140). The fetal death ratio also decreased from 6.8 deaths per 1,000 live births in 2002 to 6.1 in 2003. The majority (90.7%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (32.6%), maternal conditions (2.3%), maternal complications (12.4%), short gestation and low birthweight (3.9%), and other ill-defined perinatal conditions (27.1%). Congenital malformations accounted for 9.3% of all fetal

deaths.

Marriages

For the third year in a row and following a dramatic increase due to the passage of a new law that became effective June 2, 1999, (the new law removed the three-day waiting period for persons aged 18 and older as well as the requirement for a blood test for syphilis) the number of marriages in West Virginia decreased from 14,558 in 2002 to 13,697 in 2003. The marriage rate in 2003 was 7.6 per 1,000 population, down from 8.1 in 2002. The 2003 U.S. provisional rate was 7.5.

For all marriages in 2003, the median age for brides was 26 and for grooms was 28. For first marriages, the median age for brides was 22 and for grooms was 24. The mode (most frequently reported age) for all marriages was 23 for both brides and grooms and for first marriages was 22 for brides and 23 for grooms.

Divorces and Annulments

The number of divorces decreased by 107 or 1.1%, from 9,442 in 2002 to 9,335 in 2003. The 2003 rate of 5.2 per 1,000 population was the same as 2002. The 2000 U.S. provisional rate was 4.0 per 1,000 population.

Of the 9,335 divorces in West Virginia in 2003, the median duration of marriage was 6 years. Over half (52.5%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 23.2% of all divorces and two children were involved in 17.8%. Seven divorces involved six children.

Summary

The number of West Virginia resident births increased by 230 from 20,725 in 2002 to 20,986 in 2003. West Virginia resident deaths also increased from 20,999 in 2002 to 21,299 in 2003. The number of infant deaths decreased by 35, from 188 in 2002 to 153 in 2003. Fetal deaths of 20 or more weeks gestation fell from 140 in 2002 to 129 in 2003. Marriages decreased for the third time in five years, from 14,558 in 2002 to 13,697 in 2003, while divorces decreased from 9,442 in 2002 to 9,335 in 2003.

B. AGENCY CAPACITY

The Office of Maternal, Child and Family Health has historically purchased and/or arranged for health services for low income persons, including those who have health care financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments and recruited physicians to serve mothers and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

We have expanded income eligibility coverage for pregnant women to 185% of the Federal Poverty Level, in response to patient demand, using Title V monies. Although the Office of Maternal, Child and Family Health is less and less involved as a health care financier, we continue to provide gap filling services when indicated.

To date, SSI populations have not been enrolled in Medicaid Managed Care (MMC), and we continue to present the case that this population requires services that do not fit well within the traditional medical model. In regards to other programs, we continue to recruit providers and provide training relative to EPSDT, including training for HMO providers. We also have maintained our existing

network of outreach workers to encourage families to access primary preventive care, now offered by the HMO's.

The Office of Maternal, Child and Family Health in West Virginia is constituted of four divisions, plus a Quality Assurance/Monitoring Team, Provider Education and Recruitment Unit, and an Administrative Unit (made-up of the Office Director, and Human Resources and Operations Coordinator. With the exception of Children's Specialty Care, the Office of Maternal, Child and Family Health does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for West Virginia women and men of reproductive age, infants, children, adolescents, and children with special health care needs. In FY 2000, the Office of Maternal, Child and Family Health was assigned responsibility to use TANF dollars for developing dental/vision care for adults transitioning from Welfare to work, a program which till exists to date. Following is a brief description of the Divisions and the programs administered by Office of Maternal, Child and Famliy Health:

Division of Perinatal and Women's Health: Primary and Preventive Services for pregnant women, mothers and infants.
The focus of the Perinatal and Women's Health Division of the Office of Maternal, Child and Family Health is to promote and develop systems which address availability and accessibility of comprehensive health services for women across the life span and high risk infants in the first year of life. Administrative oversight includes an integrated perinatal care and education system paid for by Title V and Title XIX. Perinatal and Women's Health programs include the Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Program; and the Right From The Start (RFTS) Perinatal program that includes the Newborn Hearing program and Birth Score Project. Additionally, these programs provide linkage and referral to other women's, infant's, and children's services. The goal of this Division is to improve the health status of all women and infants up to one year of age, and to reduce the infant mortality rate.

Family Planning Program:
The Family Planning Program arranges and financially supports comprehensive reproductive health care for low-income women, men, and adolescents through community-based provider contractual agreements. The Family Planning Program provides reproductive health services, including complete gynecological and breast examinations, cervical cancer screening, diagnosis and treatment of sexually transmitted diseases (STDs), contraceptive supplies, pregnancy testing and referral for identified medical problems. Health education, including the importance of folic acid, and counseling are available for reproductive anatomy and physiology, all contraceptive methods, and HIV/AIDS and STD prevention. The Program offers basic infertility services with client interview, education, examination, appropriate laboratory testing, and referral to specialty care, if needed. In addition, voluntary sterilization services are available to low-risk, uninsured female and male clients.

Family Planning clinical services are offered statewide through a network of 145 locations in all 55 counties of the State. The sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. Medical services, contraceptive and clinical supplies, laboratory services, and client educational materials are purchased, in part, with Title V funds.

Adolescent Pregnancy Prevention Initiative:
Administered as a special focus area of the Family Planning Program, the Adolescent Pregnancy Prevention Initiative (APPI) focuses on statewide prevention services through education and increased public awareness of the problems associated with adolescent pregnancy. The APPI provides development, oversight, and coordination of statewide adolescent pregnancy prevention activities statewide. In West Virginia, multiple public, private and community service agencies are working diligently to reduce the incidence of adolescent pregnancy. The Office of Maternal, Child, and Family Health, Department of Education, State policy makers, administrators and school personnel have been working together to reduce teen pregnancies in West Virginia, since the 1980s.

Right From The Start Project:

The Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The project provides the following services: 1) Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national standards. 2)All participating providers complete signed agreements with OMCFH specific to services/benefits, risk scoring and patient information exchanges. 3)Title V provides financial assistance for obstetrical care for pregnant adolescents ages 19 and under who are not eligible for Medicaid regardless of income 4)Financial assistance for prenatal care for non-citizens. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation.) 5)Direct financial assistance for obstetrical care for pregnant women denied Medicaid, but whose income is equal to or less than $100 per month over 185 percent of the Federal Poverty Level. 6)Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. Services may include lab work, the initial prenatal visit, and ultrasound, if necessary. The cost of these services are paid for by the OMCFH using Title V funds. 7) Assistance for patient access to health care and the WIC Program. 8) Care Coordination for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Care Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

The Office of Maternal, Child and Family Health and West Virginia University finalized a contract for joint implementation of the Risk Reduction Through Focus on Family Well-Being (HAPI) Project, a Healthy Start grant. This Project works in tandem with Right From The Start and using Healthy Start monies from the Maternal and Child Health Bureau. HAPI participants receive additional services not provided traditional RFTS clients to include mental health and child care services. HAPI is confined to Region VII. Mental health and child care providers have signed agreements to participate in HAPI. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, and focuses on mental health issues. The long-term goal of the project is to decrease the incidence of low birth weight. OMCFH serves as the fiscal agent for HAPI.

The Smoking Cessation Program developed by Dr. Richard Windsor was implemented in West Virginia in January 2002, incorporating it into the RFTS Project. This smoking cessation program is called 'SCRIPT' (Smoking Cessation/Reduction in Pregnancy Treatment). The WV RFTS 'SCRIPT' uses the existing home visitation network and protocols established in the current Right From The Start Project. Services are provided by registered nurses and licensed social workers throughout West Virginia.

The Access to Rural Transportation (ART) Project, in conjunction with the Office of Family Support, Non-Emergency Medical Transportation Program, administers a statewide system to provide transportation dollars to needy infants and pregnant women prior to the actual medical encounter to ensure access to "medically necessary" care. The ART Project purchased approximately 13,374 transportation services in 1998, 13,009 in 1999, 15,564 in 2000 and 14,921 in 2001. Beginning in 2002, changes were made to the reimbursement process, it is now handled through another policy arm of DHHR. Because of this policy change, data collected is not available as reported in previous years.

Preventive and primary care services to RFTS infants are provided in accordance with the EPSDT Program. The ultimate goals of Right From the Start are to reduce infant mortality and morbidity, increase birth weight, increase access to prenatal and delivery care that meets nationally recognized standards, and increase parenthood preparedness, including foster home environments. Besides the above listed activities, OMCFH offers a toll-free phone line statewide for referral, improved access to care and assistance with questions or problems that patients may encounter. The State's neonatal intensive care units, the Birth Score Program, and the medical community are key players in

identification and referral of high risk infants to RFTS care coordination.

Newborn Hearing Screen:
All children born in WV are screened at birth for the detection of hearing loss. Children who fail the screen are followed and assisted in obtaining further diagnostic services by RFTS, community based agency personnel. Children who need hearing aids are referred to and assisted by Child Special Health Care Needs and WV Birth to Three.

Birth Score:
A population-based surveillance activity administered by West Virginia University in partnership with OMCFH to identify infants at risk of post-neonatal death in the first year of life and to provide appropriate interventions for those determined at risk. Every infant is screened at birth using specific screening criteria. The follow-up of these infants occurs through the RFTS network.

Breast and Cervical Cancer Screening Program:
The Breast and Cervical Cancer Screening Program (BCCSP) is a major force in the state's cancer and medical community. Implemented in 1991 through a grant from the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program, the program's purpose is to reduce mortality from breast and cervical cancers by establishing, expanding and improving community-based screening services. Many women face economic and geographic barriers that prevent them from participating in a regular program of screening. Components of the program include public and provider education, community assessment, outreach to high-risk populations, surveillance, screening, case management and follow-up services. This program links women who have cancer diagnoses to the Breast and Cervical Cancer Prevention and Treatment Act available under Title XIX with all case management provided by BCCSP staff. On April 1, 2001, WV became one of the first three states to take advantage of the passage of the Breast and Cervical Cancer Treatment Act 2000. This option allows states to provide full Medicaid benefits to uninsured women under age 65 by the BCCSP (Title XV) and in need of treatment.

Preventive and primary care services for children and adolescents:
Division of Infant, Child and Adolescent Health:
The goal of this Division is to promote parent/professional collaboration through parent participation on advisories; develop and issue medical care protocols in collaboration with the medical community to ensure provision of quality community-based services for child populations; and develop patient education and outreach strategies to encourage use of preventive health care.

Abstinence Only Education:
The West Virginia Partnership for Abstinence Only Education was established in 1997 with federal funding provided under Title V. This project is housed in the Division of Infant, Child, and Adolescent Health, and the project's primary goal is to establish community partnerships that support abstinence educational opportunities at the local level. The program is designed to increase informed youth decision-making, discourage use of alcohol and drugs, and discourage the early onset of sexual activity. Local grantees are currently located in eight regions of the state. Abstinence is administered by local grantees who agree to support the federal tenets.

The Adolescent Health Initiative:
This program is financed solely by Title V, addressing the most prevalent health risks facing adolescents today. The primary goal of the Adolescent Health Initiative is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of West Virginia. Organized training opportunities are provided by a workforce hired from the community they serve and offered in the community that the youth live. This workforce, called Adolescent Health Coordinators, are located in each of the eight regions of the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication , increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improve responsible decision making.

EPSDT/HealthCheck:
The OMCFH administers the mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, for the Bureau for Medical Services, which is also housed within the DHHR. This contract is renegotiated on an annual basis, but MCFH has administered the Program for almost 30 years.

Over 200,000 Medicaid-approved children in West Virginia are eligible to participate in the HealthCheck Program. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exam even if the service is not a part of the Medicaid State Plan.

EPSDT services include: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) immunizations; 5) hearing services; 6) laboratory tests; 7) treatment for any health problems discovered during the exams; 8) referrals to other medical specialists for treatment; 9) a check of the child's growth and development; 10) follow-up check-ups; 11) health education and guidance; and 12) documentation of medical history.

The EPSDT Program has an extensive outreach component responsible for meeting federal EPSDT informing, linking and follow-up requirements. Pediatric Program Specialists and Family Outreach Workers (FOW) are assigned to each region and county to accomplish the outreach activities. FOWs are paraprofessionals, hired and housed in the community in which they live and work. The Pediatric Program Specialists are responsible for provider recruitment, training, technical assistance and all compliance related to monitoring issues.

Children's Dentistry Project:
Works in concert with other Office of Maternal, Child and Family Health programs, Head Start and the public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services. Dental health efforts are funded from the Preventive Health Block Grant, Title V, and State appropriation. The program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children which encourage behavioral change; i.e., regular check-ups, brushing/flossing, use of mouth guards during sports activities. OMCFH has contracts with local health departments, primary care facilities and dental health care professionals serving 32 counties of the state's 55. These local health departments are responsible for oral health education efforts including working with the public school system. The Office has developed education modules which were approved by the WV Dental Association and are used in public school instruction. This program also supports fluoridation and sealant efforts.

Preventive, primary, and rehabilitative services for Children With Special Health Care Needs:
Children's Specialty Care/Children with Special Health Care Needs Program
With the retirement of the Children's Specialty Care Division Director, this program is now housed under the Division of Infant, Child and Adolescent Health. This program has a strong direct service component. The Program is structured to be community based and family-centered. Clinics are established statewide to provide services as close to family residence as possible. In addition to contracted specialty physicians, clinics are also staffed by nurses, social workers and support staff who work as a multi-disciplinary team to provide health care management services and psycho-social support. These services include: authorization of Durable Medical Equipment; assistance with transportation; development of individualized care plans and assessments; arrangements for follow-up care; assistance with classroom service accommodations; assessment of daily living skills; and assistance with transitioning to adult living and workforce entry. The OMCFH continues to work diligently with members of the SSI/OMCFH Task Force to formalize outreach and agency linkages to achieve awareness/knowledge of who and how programs can be accessed. While this cooperative agreement encompasses all disabled children, our initial efforts in 1996 targeted low birthweight babies and early intervention eligible children (birth to three years of age). More recently, the Task Force began efforts to ensure that children with disabilities who are within transitional age groups (specifically, three to six years and 16 to 21 years) receive prompt, appropriate services to enable a

smooth transition to school and/or the workplace. Through a cooperative agreement dating back more than twenty years between the Office of Maternal, Child and Family Health and Bureau for Medical Services-Medicaid, Children with Special Health Care Needs staff provide care management services to Title XIX sponsored children, which maximizes Title V monies for non-insured and/or under insured, medically indigent children.

Parent Network Specialists System
In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUUCED), Title V funds the Parent Network Specialists system. These parent/family advocates participate at all levels of CSC operations, including development of program policy and forms. Seven parents of developmentally disabled children serve an assigned regional area of West Virginia linking families to resources, information and services working through organized parent groups and CSHCN clinic settings.

Systems Point of Entry
State System's Development Initiative grant monies enabled the Children's Specialty Care system to integrate many activities into a unit now called Systems Point of Entry. Because of its growth, it has become the centralized information, education and referral center for the Office of Maternal, Child and Family Health. Families who are not eligible for CSHCN, or other MCFH services, are attended to using health, education and social service programs external to OMCFH to meet their needs.

Toll-free Lines
In June 2000, administration and responsibility of the two (2) toll-free lines were relocated to the SPE unit allowing for more efficient tracking and monitoring. In 2003, there were 34,517 calls received.

WV Birth to Three/Part C IDEA
Provides therapeutic and educational services for children age 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay. The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual child/family assessments and delivered by community-based providers who are credentialed by Birth to Three. The service system is supported by Title V, Part C, state appropriation and Title XIX.

Genetics Project
Provides clinical genetic services preconceptually and for children with congenital defects at six satellite locations under the auspices of WVU, Department of Pediatrics. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community caring for children with metabolic disease.

Division of Research, Evaluation and Planning
This Division is responsible for the epidemiological and other research activities of the Office of Maternal, Child and Family Health, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the Office of Maternal, Child and Family Health's planning efforts are data-driven. All of the Office of Maternal, Child and Family Health's program specific database and data entry personnel are housed in this Division, and are linked with program leadership to assure consistent visioning.
The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, the Childhood Lead Poisoning Prevention Project (CLPPP), and the Birth Defect Surveillance System, all sponsored by the Centers for Disease Control and Prevention (CDC); the Sudden Infant Death Syndrome (SIDS) Project mandated by State Statute but financed by Title V; and in conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project also largely financed with Title V dollars. This Division is also responsible for SSDI activities and the Block Grant application.

Pregnancy Risk Assessment Monitoring System (PRAMS)

This is a population-based surveillance system of maternal behaviors and experiences before, during, and in the early infancy of the child. The Project is an integral component of the Office. Data and information gathered by the Project are used by the West Virginia Bureau for Public Health as a resource for both the development of maternal, child and family health programs and for evaluating the new and existing programs and projects. Some of the data gathered includes smoking during pregnancy, intendedness of pregnancy, entry into prenatal care, etc.

Sudden Infant Death Syndrome (SIDS) Project
Collects and reports data regarding the occurrence of SIDS deaths in the State. When a SIDS death is reported, a local health department nurse is contacted to make a home visit to interview and assess the needs of the parents. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families. The Project coordinator, as well as, the OMCFH director are members of the Child Fatality Review Team.

Newborn Metabolic Screening Project
Works with the Office of Laboratory Services to ensure that every newborn in the State is screened for PKU, Galactosemia, Hypothyroidism and hemoglobinopathies. Any necessary follow-up is provided by state office nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. Title V state office nurses and administrative personnel track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family. Capacity is being assessed and plans developed to expand newborn screening testing to include the 29 nationally recommended tests.

Childhood Lead Poisoning Prevention (CLPP) Project
A collaborative effort between two Offices in the Bureau for Public Health, OMCFH and Environmental Health, funded by the CDC. An Advisory guides the operation of the Program, assisting the State with determining the extent of childhood lead poisoning in WV. To this end, extensive data gathering and analysis are routinely distributed. The Office of Environmental Health Services, using its local network of community-based sanitarians, provides assessment of home and environment, for residences of children with elevated blood lead levels. The OMCFH's CLPPP nurses case manage all children with positive BLL of >10mcg. Recent 2002 legislative action has resulted in the mandated screening/assessment of all high risk children age of 6 and under for lead poisoning.

Birth Defects Surveillance System
Tracks the incidence of specific diagnostic codes using the birth files, death files and hospital charts of the infant as well as the mothers. All infants identified with a birth defect are referred to CSHCN for services and referrals.

Quality Assurance/Monitoring Unit
The OMCFH Quality Assurance/Monitoring Team has over 25 years proven experience in conducting on-site clinical review. These reviews occur with every medical provider who contracts with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program. Technical assistance and corrective action plans are the next step in the process.

C. ORGANIZATIONAL STRUCTURE

West Virginia's Office of Maternal, Child and Family Health is located within the State's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources. The Bureau's overall goal is to attain and maintain a healthier West Virginia.

The Office of Maternal, Child and Family Health provides operational guidance and support to providers throughout West Virginia to improve the health of families. In addition to providing funding support for actual service delivery, the Office of Maternal, Child and Family Health funds projects intended to develop new knowledge that will ultimately improve the service delivery of the health community.

The Office of Maternal, Child and Family Health is comprised of multiple divisions, programs, and projects all designed to promote improved health including access and increased utilization of preventive care. The Office of Maternal, Child and Family Health's organizational structure includes the Division of Perinatal and Women's Health; Division of Infant, Child and Adolescent Health, including Children with Special Health Care Needs; Division of Research, Evaluation and Planning; and the Division of Financial Services. In addition, the OMCFH supports a Quality Assurance Monitoring Team. (Office of Maternal, Child and Family Health organizational chart as attachment).

D. OTHER MCH CAPACITY

In all, there are 219 staff positions in West Virginia's Title V agency. Of these positions 6 are senior management, 60 professionals, 25 medical professionals, 104 clerical workers, 9 technicians, and another 15 professionals under contractual hire.

During Fiscal Years 1997 and 1998, two parent advisors were recruited by the Office of Maternal, Child and Family Health, one as a paid employee and the other as a volunteer. These positions have been maintained, and additional parent-to-parent coordinators located in the community and hired through contract with the WVU Center for Excellence in Disabilities (UAP) have been increased to five. Parent advisors are trained alongside our developmental disabilities community related to advocacy, public presentation skills, and public policy development. The parent advisors participate in CSC clinical activities and document activities for inclusion in the medical records. Parent Advisor reports are color coded and used as documentation of additional service needs, such as specific medical information, special consideration requests, etc.

Children's Specialty Care funds the Parent Network Specialists system, through a contract with the WVU Center for Excellence in Disabilities. These parent/family advocates participate at all levels of CSC operations(Part C and CSHCN), including development of program policy and forms. During the year 2002, this network was expanded to four (4) parents of developmentally disabled children, each serving a regional area of West Virginia. The was expanded to six (6) Parent Network Specialists in 2004.

Brief biographical sketches follow of the Office Director and the Division Leaders:

Patricia Moore-Moss, MSW, LCSW--Director Office of Maternal, Child, and Family Health
EDUCATION:

West Virginia University; School of Social Work, 1976 - M.S.W.
West Virginia State College, 1973 - B.A. Sociology - Social Work
M.S.W./L.C.S.W. - License No. CP00208394

PROFESSIONAL EXPERIENCE:

Director of the Office of Maternal, Child and Family Health (4/92 to Present)
Bureau for Public Health
Office of Maternal, Child, and Family Health
Social Service Consultant - Charleston Area Medical Center (1990 - 1992)
Bureau Administrator Social Services (9/88 - 11/89)

Assistant Director (1988 - 1989)
West Virginia Department of Health
Division of Maternal and Child Health
Executive Assistant to the Director (1986 - 1988)
Maternity Services Program Director (1980 - 1986)
Social Worker/Patient Educator (1/79 - 6/80)
West Virginia Department of Health
Improved Pregnancy Outcome Project
Assistant Director of Social Services (8/76 - 12/78)
Charleston Housing Authority

Kathryn G. Cummons, MSW, ACSW--Director, Division of Research, Evaluation, and Planning
EDUCATION:

Master's of Social Work, West Virginia University, Morgantown, WV (1988)
Bachelor's of Social Work, West Virginia University, Morgantown, WV (1974)
Minors in Psychology and Speech
Attendance at a variety of training and educational seminars on a wide array of topics throughout the past 28 years related to employment at the time.

PROFESSIONAL EXPERIENCE:

Director, Research, Evaluation, and Planning (9/2000 - Present)
Bureau for Public Health
Office of Maternal, Child, and Family Health
Clinical Social Worker, (12/99 - 9/2000)
Comprehensive Psychological Services
Clinical Social Worker, (9/89 - 7/90) and (5/98 - 12/99)
Charleston Area Medical Center
Director of Social Work Services and Discharge Planning (8/90 - 5/98)
Charleston Area Medical Center
Administrator (7/84 - 5/89)
Northern Tier Youth Services
Supervisor, (6/81 - 7/84)
Lutheran Youth, and Family Services

Phil Edwards, M.A.--Director, Division of Infant, Child and Adolescent Health (including CSHCN)
EDUCATION:

Marshall University, Bachelors in Accounting, 1974.
Marshall University Graduate College, Masters in Industrial Relations, 1992.

PROFESSIONAL EXPERIENCE:

Director, Division of Infant, Child and Adolescent Health (1/01 to Present)
Office of Maternal Child and Family Health
Bureau for Public Health
Coordinator of the Abstinence Only Education (AOE) Project (10/99 - 1/01)
Program Specialist for EPSDT HealthCheck (1995 - 1999)
Administrative Assistant, Division of Women's Services (1993 - 1995)
Fiscal Officer, for Women, Infants and Children Program (1989 - 1993)
Office of Nutritional Services
Fiscal Officer, Administration (Central Office) - (1980 - 1989)
Office of Maternal, Child and Family Health

Patricia A. Meadows, RN - Director, Perinatal and Women's Health Division
EDUCATION:

Beckley College, 1981 - 1982
Bluefield State College, 1982 - 1984 (Associate's Degree in Nursing)
West Virginia State College, 1998 - 1999 (Bachelor of Arts Degree)
University of Phoenix, 2001 - 2003 (Master's in Organizational Management)

PROFESSIONAL EXPERIENCE:

Program Director of Perinatal and Women's Health Division, Office of Maternal, Child and Family Health (2004)
Assistant Administrator, Trauma/Renal/Emergency/Pre-Hospital Services, Charleston Area Medical Center (2000 - 2004)
Program Director, Trauma Service Director, Charleston Area Medical Center (1996 - 1999)
Nurse Manager, Emergency Services, Charleston Area Medical Center, General Division (1991 - 1996)
School Nurse, Johnson County Department of Health, Paintsville, Kentucky (1989 - 1990)
Nurse Manager, Emergency Department, Raleigh General Hospital, West Virginia (1984 - 1989)

E. STATE AGENCY COORDINATION

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements for services offered through the Right From The Start Project, Family Planning and Children with Special Health Care Needs. The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). The Memorandum of understanding is attached without signatures but the complete agreement with official signatures may be requested from the OMCFH. The Office of Maternal, Child and Family Health has administrative responsibility for dental and vision care for persons moving from Welfare to Work. These efforts are financed by TANF resources; a copy of the grant agreement may be obtained from The OMCFH. As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement has been finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V, the agreement established the Office of Maternal, Child and Family Health as the sole provider of early intervention services. The Department of Health and Human Resources has contracted with a private agency to serve as a central finance office to coordinate all funding sources for early intervention services, a centralized data system, and claims. This was let as a request for bid and is administered outside of state government by Covansys.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include birth score, birth defect registry, pregnancy tracking systems, metabolic screening, childhood blood lead level screening, and newborn hearing screening. In addition, because we administer the EPSDT Program, children who have conditions that may be debilitating and/or chronic disease, are referred to CSHCN for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established in 1980, average close to 3,000 calls per month. Each caller receives individualized follow-up to assure the referrals and pertinent information related to the request met their need. Callers are also contacted by an administrative entity within OMCFH to ascertain the caller's satisfaction with our services. This quality assurance monitoring is prepared using random sampling.

OMCFH toll free lines always receive accolades. Evaluation materials are on file and available if desired.

West Virginia Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Program, Department of Education, the March of Dimes Chapter, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Another initiative made possible was the Richard Winsor, smoking cessation program in partnership with the Office of Epidemiology and Health Promotion who contributed tobacco funds for the purchase of CO2 monitors by the 233 care coordinators for use with pregnant women statewide.

Agency Partners include: (list not all inclusive)
-400+ medical contracts with private physicians, community health centers, local health departments and hospital based clinics for the provision of EPSDT.
-Birth to Three/Part C provides grants to local entities to act as system point of entry for eligibles.
-Memorandum of Understanding with WIC and SSA for referrals as referenced earlier.
-Working agreement with the Office of Social Services (Title IVB) for children in state custody to receive enhanced health screens through MCFH's medical provider networks.
-Working agreement with the Office of Social Services for interagency training for professionals and para-professionals serving young children-including use of assistive technology and understanding ADA.
-Agreements with WVU for genetic services and administration of the Birth Score Project.
-145 agreements statewide with private physicians, community health centers and local health departments for Title X family planning services.
-153 agreements statewide for breast and cervical cancer screening program services.
-Agreements with 8 agencies to locally administer the Right From The Start Project and subsequent agreements with multiple agencies to provide direct services to perinatal populations who employ over 233 licensed social workers and nurses
-March of Dimes
-Developmental Disabilities Council
-Medical Advisories for all programs and projects
-University Affiliated Program, Consumer Advisory Council membership
-Interagency Coordinating Council for Birth to Three/PartC (state statute established).
-Department of Education/Healthy Schools
-Starting Point Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies)
-Governor's Cabinet on Children and Families
-Head Start
-Cancer Coalition (established state statute)
-Membership, West Virginia Association of Community Health Centers
-WV Commission for the Deaf and Hard of Hearing (Board Member)
-Women's Health Advisory Council
-Children's Mental Health Collaborative
-All Offices within WV DHHR

All agreements and contracts are kept on file within the West Virginia OMCFH.

Coordination among agencies, community partnerships, and parents is discussed throughout the application and the Five-Year Needs Assessment.

F. HEALTH SYSTEMS CAPACITY INDICATORS

#1--The rate of children hospitalized for asthma (ICD-9 Codes 293.0-493.9) per 10,000 children less than five years of age.

The escalation in the prevalence of asthma among children over the past two decades has been noticeably greater than that among adults. For children under age five, the increase in prevalence between 1980 and 1994 was 160 percent, while the corresponding increase for the general population was 75 percent. Although there are more adult than child asthmatics, the prevalence of asthma among children is higher.

In West Virginia, in 2003, there were 1,252 hospital discharges for asthma for children under the age of five (5). There is an estimated 12.4% of WV high school children who suffer from asthma according to the Youth Tobacco Survey. Approximately 10.3% of middle school students and 8.8% of high school students had an attack of asthma in the past one year. WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. In August of 200l, the OMCFH wrote a letter of support for a CDC sponsored grant submitted by the Office of Epidemiology and Health Promotion through their Tobacco Prevention Program. Appropriately so, tobacco monies are also being used to address the environmental factors that increase the risk of developing asthma or exacerbate the disease. The grant was approved to enable the development of a statewide plan to address prevention and treatment of asthma efforts. Although the OMCFH is not the home of the asthma initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

A West Virginia Asthma Coalition was formed with members from public health offices as well as community physicians and other interested agencies. In the information discovery phase a startling finding was that more students with asthma smoke than those who don't have asthma. The Coalition's role is one of prevention through education, establishing disease reporting parameters and mechanisms enabling tracking of incidence levels, advocacy for inclusion of benefit coverage across all payors for those affected by the disease, and payment for screening and prevention activities. There also remains the responsibility to assure screening, treatment, etc., is available and accessible to all, an assignment which exceeds the scope of health care financing available to MCFH.

#2--The percent Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening.
The OMCFH administers the mandated Medicaid EPSDT Program (HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages their participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-screened according to periodicity tables established by the American Academy of Pediatrics; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation assistance and help with appointment scheduling. In WV, 95% of children under the age of one (1) who receive Medicaid, receive at least one initial or periodic screening. The HealthCheck Program focuses on recruitment and training of providers to assure compliance with program protocols, and targeted outreach by phone and mail.

#3--The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.
As of April, 2004, 24,400 children ages 0-18 were covered by SCHIP in WV. It is estimated that another 22,701 children in WV are eligible for SCHIP. The WV Healthy Kids Coalition has provided extensive outreach since the inauguration of SCHIP and have enrolled over 41,000 children since its inception.

According to HEIDIS information, reviewed by CHIP on enrollee information, during FY 2003, 100% of children less than 1 year of age received a health screen.

#4--The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

According to 2003 WV Vital Statistics, 26% of women had 6-10 prenatal care visits, 56.4% had 11-15 prenatal care visits and 11.2% had 16 or greater prenatal care visits. This represents 84.6% of women whose observed to expected prenatal care visits were adequate or greater based upon the Kotelchuck Index.

West Virginia's perinatal program (RFTS) provides comprehensive maternity care for government sponsored pregnant women whose income is at or below 185% of poverty. These services are paid for by Medicaid and Title V. (Legal aliens and adolescents are also provided coverage using Title V monies.) Medical case management for high risk women and infants is provided to facilitate entry into, and receipt of, appropriate health care for populations who, because of medical conditions/predilections, might otherwise not have appropriate or available care. Components include: 1) intensive outreach statewide to identify pregnant women; 2) operation of statewide toll-free line to link pregnant women to obstetrical services; 3) tracking of positive pregnancy tests by community care providers to link patients to care; in the event this fails, follow-up is provided via phone and/or home visitation; 4) all women are screened for risk conditions; 5) initial prenatal visits, lab, etc is defrayed by Title V, if a woman is pregnant and has no means of paying for health care. The patient is given information on how to access Medicaid, including the opportunity for submission of patient-self-completed Medicaid application including the opportunity to complete an online application.

#7--The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.
The Children's Dentistry Project (CDP) is a component of the Division of Infant, Child and Adolescent Health and is housed within the OMCFH. Preliminary data for 2003 suggests that 48% of West Virginia Medicaid recipients aged 6-9 received a dental service. In West Virginia, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments adversely affects willingness of dentists to serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health.

The CDP currently has 17 contracts with local health departments, primary care facilities and individuals to offer oral health education to students in public schools. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. The CDP contracts with local dentists to purchase all supplies and perform all billing functions. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access.

There are significant numbers of West Virginians who do not have a fluoridated water supply. Some of those receive water from public systems. Fluoridation equipment is expensive and supplies are no more than $3 per customer per year. The savings in future dental caries is 5 to 6 times that amount. For example: For a town the size of New Martinsville (currently not receiving fluoridated water), the annual cost of fluoridation would be $25,500. If only one cavity is prevented in an entire family, the net savings for the community is $124,200 annually. The CDP is beginning a project to work with a limited number of local communities and water systems to advocate for fluoridation and to assist communities to be able to obtain fluoridation. A small amount of funding is available to pay for necessary equipment. The Office of Environmental Health Services has been approached as a non-funding partner and is wiling to participate. Other funding sources are currently being explored. The infrastructure development will have lasting implications and may be supported through the Governor's Office of Community Development.

The CDP is currently working on a pilot project in McDowell County for a school-based dental clinic. The CDP has purchased equipment and supplies for this project. In addition to preventive services, students will be provided with oral health education materials and referred to local dentists for restorative care when necessary. Through this pilot project, over 4,000 students in McDowell County Schools have received toothpaste, toothbrushes, and dental floss. The CDP is also partnering with

other Primary Health Care Facilities to offer school-based dental services and oral health education to students in Lincoln, Marshall, Jackson, Ritchie and Calhoun counties.

To design effective health promotion campaigns and materials, we must know what the customer is thinking. The CDP is implementing a research project in conjunction with higher education to learn more about the attitudes of youth and parents toward dental care, and learn more about the barriers to receiving dental care. To date, 2,359 surveys have been returned and are being processed through data entry.

#8--The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program.
The CSHCN program advances the health and well-being of children and youth with chronic health care needs, including those with cleft lip and palate, neurologic, and cardiac problems. The goal is to facilitate early care, offer consultation and clinical intervention, care management and planning, as well as to support the family and community in the care of children with special health care needs. The program provides services for children birth to age 21 years. Components of the Program include: 1) assessment of children with special health care needs and enrollment in clinical care or referral to alternative sources as medically indicated; 2) participate in development of multidisciplinary treatment plans; 3) acts as resource support to increase awareness of and need for primary, preventive health care; 4) establishes linkages with sub-specialty physicians, therapists and other providers; 5) CSHCN staff provide care management, including developing and monitoring treatment plans, assisting families with scheduling and transportation, and referral to other community services; and 6) adolescent/adult transition planning, including referral for work/training. All clinical services, including physician credentialing, peer review, and care protocol development are overseen by the CSHCN Medical Advisory.

In CY 2004, 6,856 children/youth were served in 48 specialty care clinics state-wide by 52 participating clinicians. Within the clinic system there were 3,447 visits and 535 diagnostic evaluations were completed. There were 1,256 transition services to youth ages 14,16,18 and 21. 81.99% of children participating CSHCN are Medicaid beneficiaries. This high percentage is attributed to CSHCN Program's commitment to assisting families with SSI application, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group. For CY 2004 there were 1,459 number of children ages 0-18 who received SSI and also received CSHCN services. As of December 2003 there were 8,219 children in WV under the age of 18 receiving SSI benefits indicating that the CSHCN Program served 19.07% of WV children under the age of 18 who received SSI benefits.

In the needs assessment we prepared information about children receiving SSI by age and presenting conditions. It is apparent that many WV children receiving SSI have a diagnosis not covered by CSHCN, such as serious emotional disturbance (SED), autism, etc.

Children are seen more frequently if medically indicated; consequently, children with cystic fibrosis attended CSHCN clinics more often than children with hearing impairments or those needing eye surgery. Since a child/family may not be equally in need of social service support, the CSHCN Program has developed a mechanism for determining the level of social service need. The determination of client need is a part of the overall child/family assessment which is developed as part of a multi-disciplinary process, with the child/family as the pivotal element.

All children assessed by CSHCN receive evaluation and case management services to facilitate access to alternative systems of care. All children enrolled in CSHCN, Birth to Three (Part C/IDEA), or even our perinatal RFTS Program receive care management and care coordination.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Office of Maternal, Child and Family Health, Bureau for Public Health, Department of Health and Human Resources, is the "single state agency" for Maternal and Child Health in West Virginia. The OMCFH plans, promotes and coordinates a statewide system of comprehensive health services for women, infants, children, adolescents, and families of children who have special health care needs. The Office is known for longstanding community partnerships between the public and private sector which has ultimately resulted in improved health status and access for maternal and child health populations.

The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreements. The exception to this format is CSHCN, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred. It is also important to note that the State's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C/IDEA. In addition, OMCFH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff employed by EPSDT, who serve as technical resources to the medical community. A portrayal of how the system works is depicted in the diagram in the attachment. The West Virginia Office of Maternal, Child and Family Health, in collaboration with multiple agencies, family groups, and individuals, has determined several needs across the service system. The needs, as identified, have been linked to Healthy People 2010 Objectives when possible and are listed by targeted populations; i.e., perinatal, children, adolescents, and children with special health care needs.

Families of children with special health care needs require the same sorts of support as do families with children who do not have special needs; that is to say, they require basic health care, education, recreation, socialization, transportation, and other systems to support them in their roles as family members and to help them raise children to be healthy, responsible, competent adults. All families need these systems to be available, accessible, and responsive to their needs.

As a result of multiple surveys and public forums, several overall system needs became apparent. Within the Direct Health and Enabling Services category, West Virginia is severely lacking in respite services. Respite services are almost non-existent, even for high need, targeted population groups like Medley class members who were previously institutional residents. In addition, all focus groups reflected the importance of self-determination needs in the state. The State OMCFH received multiple documentation that reinforces this priority need.

Within the Population-based Services category, surveys and public forums, the Medley class survey and the Developmental Disabilities Council survey, show that oral health services are cited as the greatest need among adults with disabilities. There is no oral health care financing for adults in that Title XIX does not offer coverage and the previously referenced Pre-employment Project, administered by MCFH is limited to adult populations returning to the work force. Also, even when children have health care financed (Medicaid), there is poor utilization of oral health services. Finally, survey results confirm that vocational transition services are in need of renewed support in West Virginia. Approximately 1/3 of survey responders indicated the need for children to receive transition

or vocational planning.

Causes of infant death, low birthweight and maternal smoking must be addressed. Within the Infrastructure building category, recruitment and retention of qualified medical and other service delivery personnel in WV must receive priority attention in the future. Moreover, insurance systems within the state infrastructure require modification to better accommodate children and families in WV. Recognition of CSHCN services to include reimbursement for non-traditional services such as intervention by licensed behaviorist and other professionals must become a priority.

B. STATE PRIORITIES

Each current state performance measure was selected because of the health status of the respective population. For example, we have worked hard for years to assist Title XIX sponsored patients with early entry into prenatal care; however, we still have not achieved the 90% first trimester enrollment goal of Healthy People 2010. Furthermore, WV women continue to smoke during pregnancy and an extraordinary number of WV children are exposed to second hand smoke.
In an effort to improve population-based surveillance systems, WV pursued CDC funding for lead screening of its children. This money was used to build capacity at the State Laboratory including the purchase of a graphite furnace. It was our intention to identify children within the first six months of life who have or are at risk of developmental delays, so the addition of lead screening activities only served to strengthen this population-based surveillance activity. WV also pursued other CDC funding which included enhancing the Birth Defects Surveillance System.
We also have cervical cancer as one of the leading causes of death of WV women, and the opportunity to offer breast and cervical cancer screening for high risk women who might not otherwise access appropriate medical screening is a part of our effort to improve the quality of life for West Virginians. We also track WV women who have HPV, and subsequently follow how many of these women develop cancer of the cervix.
If every West Virginian is to have improved health status, we need to help families plan and space pregnancy. This has continued to be a challenge, and even with 150 family planning clinics offering services statewide, we still have unintended pregnancies that ultimately have implications for child well being and family functioning. Following is a list of needs by the levels of the pyramid:

Direct and Enabling Services
1) Key insurance systems within the state require modification to better accommodate the needs of children and families in WV. For example the Public Insurance Program does not provide coverage for hearing aids so CSHCN must purchase the equipment.
2) Persons with disabilities have declared the right to self-determination and advocacy as a WV priority. Included in this declaration is the issue of independent living, meaningful employment opportunity, etc.
3) Adolescent health service utilization needs to be increased and additional resources dedicated to affecting behavioral changes such as increased use of seatbelts, decreased use of alcohol and tobacco, increase in the number of adolescents abstaining from sexual activity, and decrease in school drop outs.
4) The number of women smoking during pregnancy must be decreased.

Population-Based Services
1) Quality contraceptive health services must be universal as a means of supporting healthy families and reducing unintended pregnancy.
2) All children must have a source of health financing and a health home.
3) Oral health services in WV should be improved, and their availability augmented, both for children and adults, especially adults with disabilities. Oral health must be integrated into general health.
4) Attention must be given to causes of infant death in WV - reduce the infant mortality rate.

Infrastructure
1) Recruitment and retention of qualified medical and other service delivery personnel in WV must be given increased attention.

2) Specialty medical services for children with chronic debilitating conditions are a priority as is the improved availability of obstetrical services.
3) An adequate supply of safe and enriching center-based care must be available where acceptable relative care is unavailable with adequate subsidy to allow parents to work.
4) To reduce the proportion of women smoking during pregnancy.
5) To reduce the proportion of unintended pregnancies.
6) To increase the proportion of women receiving first trimester prenatal care whose prenatal care is paid for by Medicaid.
7) To increase the proportion of women >18 receiving Pap smears within the preceding three years.
8) To increase the proportion of eligible children who receive EPSDT services.
9) To identify as early as possible all children at risk of chronic or debilitating conditions and arrange for appropriate care.
10) To increase the proportion of age appropriate children screened for blood lead.
11) To increase the number of children receiving oral health care, with special emphasis on children whose health care is paid for by CHIP and Medicaid.
12) To increase the proportion of women >50 receiving mammograms within the preceding two years.
13) To reduce the incidence rate (per 100,000) of females aged 15-19 years diagnosed with Chlamydia.
14) To continue to work cooperatively with the Division of Surveillance and Disease Control, which is responsible for the STD Program. Patients participating in Family Planning are routinely screened for STDs.

West Virginia has developed new priorities and performance measures using the Five-Year Needs Assessment and discussed in detail within that document.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	98.5	99	99.5	99.5	100
Annual Indicator	98.6	99.8	100.0	99.1	99.2
Numerator	21421	20950	21123	21280	21300
Denominator	21718	21001	21132	21480	21480
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

data source: State lab and OMCFH Newborn Screening Program

Notes - 2003

Denominator information for 2003 is provisional from the Vital Statistics Division. Numerator information was received from the State Lab.

Notes - 2004

Estimated

a. Last Year's Accomplishments

In 2004, the WV Newborn Metabolic Screening Advisory Committee, as well as the Bureau for Public Health task force, recommended that the WV Newborn Metabolic Screening Program increase the screening panel to include the 29 recommended tests. The task force developed a feasibility study with accompanying recommendations to enhance screening ability. Project financing is the biggest stumbling block.

Recommendations included: 1) expanding the Newborn Metabolic Screening Program to include all 29 recommended tests by gradually adding tests, 2) increase capacity of the State Laboratory by providing equipment, as well as personnel and space, 3) increasing case management and educational components within OMCFH, 4) increasing capacity of genetic and counseling services and 5) billing for all program costs using the newborn screening kits ordered by hospitals.

In 2004, 99.1% of infants born in the state of WV received newborn screening. In conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project ensures that infants are screened for inborn errors of metabolism before hospital discharge. All abnormal test results are followed-up by Office of Maternal, Child and Family Health staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at West Virginia University. The Office of Maternal, Child and Family Health provides, free of charge, regardless of family income, formula for those with confirmed PKU. The OMCFH, using Title V dollars reimburses the State Lab for all newborn screening specimens.

The Genetics Program at West Virginia University provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling.

OMCFH staff routinely visits birthing hospitals as a means of identifying and resolving any problems or concerns.
Linkage of data from the State Laboratory and the Project have been reestablished creating a more efficient process.

One of the goals of the State Laboratory is the reduction in the numbers of specimens submitted to the laboratory which fail to meet the criteria established for a satisfactory specimen. Such failure results in compromised or no test results, making a repeat blood collection necessary, which is a great inconvenience to the patient, and a repeat test, which is time consuming and expensive for the OMCFH. The two principal reasons for repeat testing are (1) the inadequacy of the specimen, and (2) the collection of the initial specimen too soon after birth.

During the first year of collecting test data, 1996, the percentage of tests that had to be repeated was 20.8%. In 2004, this percentage had dropped to 4%.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. All abnormal test results are followed by OMCFH case management.		X		
2. The pediatric genetics program at WVU provides six subspecialty clinics throughout WV.				X
3. An active advisory committee was re-established to assist with policy and program development.			X	
4. The NBS Project staff work collaboratively with the State Lab to ensure screening before discharge.			X	
5. Formula for PKU patients is provided free of charge, regardless of income, by OMCFH.		X		
6. Linkage of data between OMCFH and the State Lab has been re-established creating efficiency.				X
7. The Bureau for Public Health issued policy requiring universal testing of all infants for Hemoglobinopathies.				X
8. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
9.				
10.				

b. Current Activities

Currently, all newborn metabolic screening and intervention efforts are financed through Title V and state appropriations including nutrition supplements and genetic and counseling services contracted through West Virginia University. West Virginia currently tests for six (6) of the 29 newborn screening tests recommended by the March of Dimes and the National Newborn Screening Advisory Council. This includes the Newborn Hearing Screen.

Beginning July 1, 2003, all infants born in WV received testing for Sickle Cell Disease. In response to national practice standards, the Bureau for Public Health then issued policy requiring testing of all infants for sickle cell disease. Five physicians at 3 strategic locations statewide, are providing follow-up clinical services for this population and providing consultative services to private providers throughout the state. The OMCFH has assisted the medical community in developing the capacity to provide treatment, genetic testing and follow-up services to the population with positive results for Sickle Cell Disease.

The OMCFH maintains its well-established, positive working relationship with the State Lab, as well as, the private physicians who manage the children diagnosed with inborn errors of metabolism. All children who test positive receive case managment from a nurse within the Newborn Screening Program. A referral is made to CSHCN for additional follow-up services.

West Virginia is participating in the regional collaborative to assist states in identifying expert shared resources.

c. Plan for the Coming Year

The WV State Laboratory has contracted with Neometrics to upgrade their newborn screening software capabilities. The OMCFH will continue to work with the Office of Laboratory Services to ensure that every newborn in the State is screened for PKU, Galactosemia and Hypothyroidism as well as hemoglobinopathies. Any necessary follow-up will continue to be provided by state office nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism will continue to receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH and other medical experts in geographically assigned areas of the state. Title V state office nurses and administrative personnel will also

continue to track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family.

The financing piece will also be phased in using an existing fee for services rule allowing the State Laboratory to bill $28 per kit. As the program expands allowing for additional tests, the fee for service charge will increase to cover all costs associated with the Newborn Screening Program. The hospital will pay for kits and then capture their costs through insurance reimbursement.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			65	65	75
Annual Indicator			56.1	56.1	56.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Parents or legal guardians are involved in the decision making for their child through the Patient/Family Assessment process and the development of the Patient Care Plan. A multi-disciplinary team approach is used to provide care-planning and care-coordination to CSHCN and Birth To Three Part C/ IDEA program participants. The multi-disciplinary team includes the child/parent, physicians, nurses, social workers, therapists, school systems, vendors and community services supports who are providing care for the child. Team members, led by the CSHCN nurse and/or social worker, collaborate with the child/family in developing an

appropriate, comprehensive care plan for the child.

In Birth To Three, individual child and family assessments are developed for every participant by a multidisciplinary team. Services to be offered based on the care plan are provided by practitioners enrolled in Birth To Three and selected by the family. Each Birth To Three Regional Administrative Unit ahs a full time Parent Coordinator to serve as a liaison between the program and families. These positions are paid for by the OMCFH using Part C funds.

During CY 2004, 1,755 CSHCN Program patient care plans were completed to assure a continuum of comprehensive medical care and transition to adult care as appropriate. Plans are copied, signed and reviewed with parents. Transition services also involve parents, education specialists and other interested parties. Transition screening tools have been newly developed according to age appropriateness and added as part of the process. Transition services were provided to 1,256 youth, ages 14 to 21.

Parents of children with special needs participate in advisories for Birth To Three and CHSCN. Also parents are supported with stipends so they can participate in self-determination workshops, the Fairshake Network and other advocacy groups.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with Marshall University in Parent Partners in Education (PPIE) funding results in parent advocates placed in Cabell-Huntington Hospital PICU and Pediatric Clinic.				X
2. Parent/Professional Collaboration Conference sponsored by OMCFH and Marshall University Pediatrics.		X		
3. Survey of parents to determine priority topics of interests/concerns conducted by Center for Excellence through contract with OMCFH.				X
4. The OMCFH Monitoring Quality Assurance unit conducts call-backs of Systems Point of Entry contacts to determine satisfaction.				X
5. Parents participate as part of the care coordination team for development of individual care plans.		X		
6. The parent signs the Care Plan to indicate their agreement with the plan.		X		
7. Copies of Care Plans and updates are shared with the child's parent.		X		
8. Care Notebook and Resource Manual were revised for distribution to families and applicants.		X		
9. Paid Parent Coordinators, one in each of the Birth To Three Regions are available to families.				
10.				

b. Current Activities

To include parents' voices and advice on decision making at the administrative level, the CSHCN Medical Advisory Board was reconstituted and expanded to become the more inclusive CSHCN Program Advisory in April 2004. The membership of the Program Advisory was diversified to include adolescents, parents, representatives from state and private agencies, and medical professionals, all of whom have provided or received services through

the CSHCN program. The Program Advisory advises the Commissioner of the Bureau for Public Health relating to the care and treatment of children receiving services from CSHCN. The Advisory choose to concentrate their efforts in the area of family-centered care. They reviewed the recently revised Care Notebook and Resource Guide; began development a training packet for parents on how to best use the Notebook; and plan to work with pediatricians and primary care physicians to encourage the use of the Notebook as a tool in care management for children with special health care needs. This action exands the use of the care notebook beyond participants of the CSHCN Program.

The partnering of parents in decision making at all levels of CSHCN is demonstrated through the participation of Parent Network Specialists (PNS) at all levels of program administration and operation. The PNS system is administered by the Center For Excellence for Disabilities (CED). The PNS have direct contact with program participants through clinic attendance and community group presentations.

During CY 2004, the PNS made 946 direct contacts with families of children with special health care needs through home and hospital visits, in addition to clinic sessions. The PNS made 18 presentations to community and educational groups about the CSHCN program services.

Revision and reprinting of the Care Notebook and Resource Manual were completed in March 2004.

c. Plan for the Coming Year

During FY 2005, Patient/Family Assessments and Care Plans will be completed for all program-enrolled children through home visits and/or other face-to-face contacts. Priority will be given to newly enrolled children and to children requiring transition services, pre- and post-surgical care; private duty and intermittent skilled nursing; nutritional assessment; child protective services; technology dependent, and those requested by physicians, clinics, other agencies.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective					
Annual Indicator			56.9	56.9	56.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	60	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Information about a child's primary care provider (medical home) is gathered by the Systems Point of Entry Unit during initial intake, and by CSHCN staff each time a child presents for service. During CY 2004, 3,724 children who received CSHCN services had an identified primary care practitioner. This represents 81.7% of children in enrolled and pending status with CSHCN. SPE service coordinators link children without an identified primary care practitioner to the OMCFH administration's Health Check Program, and to local sources for medical care. All children receiving benefits through the WV Medicaid Program, including participants in the CSHCN Program, are assigned a primary care physician either through the Physician's Assured Access Service (PAAS) Program or through the Medicaid Managed Care program.

Copies of medical records, depicting care provided by CSHCN are sent to the participating child's primary care provider to assure coordination of care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN intake information captures primary care provider (medical home) information.				X
2. CSHCN information is shared with the child's primary care physician with permission from the child's guardian.		X		
3. Systems Point of Entry assists applicants to find primary care medical provider.		X		
4. Appropriateness of specialty medical care reviewed by CSHCN Medical Associates.				X
5. Nutritional assessments available to CSHCN children through Center for Excellence in Disabilities contract.	X			
6. Primary care (medical home) information included in CSHCN Patient/Family Assessment and Care Plan.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Efforts are made to coordinate the CSHCN specialty care provided with the child's medical

home, and to keep the primary care physician informed of treatment plans. CSHCN strives to provide service in a manner that is accessible, family-centered, and coordinated. Care coverage is provided throughout the state in either a specialty care physician's office or in face to face contacts in a CSHCN clinic site closest to a child's home. Medical transportation costs for appointments are reimbursed at the DHHR Medicaid established rate. The child and the principal care-givers are informed of treatment options and involved in development of the patient care plan for the child. Care is continued until the child's 21st birthday with transition services available to prepare for independence. Through the Patient/Family Assessment and patient care plan development process families are linked to support, educational, and community-based services.

To ascertain the appropriateness of specialty medical care and application of program policy, the CSHCN medical associates review case records of enrolled children. The CSHCN Orthopedic Associate reviewed over 1000 records of children being followed for orthopedic care. Similarly, the CSHCN Otolaryngology Associate reviewed 80 records of children followed in the Charleston Plastic Surgery Clinic. During the coming year, the CSHCN Otolaryngology Associate will review the records of all children receiving hearing and Ear, Nose, and Throat services. Additionally the 90 records of children receiving nutritional supplements will be reviewed by the pediatric associate. These peer reviews were to assess appropriateness and the quality of care provided program participants.

c. Plan for the Coming Year

The annual review of CSHCN clinic services revealed there should be a limited expansion of clinic services during FY 2005. To provide enhanced services in an underserved area of the state, the reestablishment of an ENT clinic is being considered in conjunction with the West Virginia School of Osteopathic Medicine, in Lewisburg, WV.

CSHCN will continue to work with the WV Medicaid Managed Care Program to assure the needs of children with special health care needs are addressed. The planned expansion of WV Medicaid Managed Care Program, through contracted health maintenance organizations, will have a continuing impact on the provision of care for children with special health care needs. The Medicaid program plans that all Medicaid beneficiaries, except the SSI population and foster children, will be covered by a health maintenance organization within the year.

CSHCN will continue to work with the WV Chapter of the American Academy of Pediatrics to encourage the medical community to refer children with chronic, dibilitating conditions to the CSHCN Program.

CSHCN will continue to collaborate with another office within the Bureau for Public Health, Office of Nutrition's Special Supplemental Nutrition Program for Women, Infant, Children (WIC) to assure children who are age eligible to receive WIC are identified.

The WV Medicaid Program does not provide coverage of nutritional or feeding supplements taken by mouth. Young adults receiving such supplements lose funding for medically necessary prescribed supplements when the young adult transitions from CSHCN at age 21 years. The WVU Center for Excellence in Disabilities (UAP), CED, nutritionist plans to work on the issue of funding formulas for children on feeding tubes. If successful in securing funding, the CED nutritionist will develop a transition program that will target adolescents on feeding tubes when they turn 18, 19 or 20 years old.

CSHCN has worked with OMCFH's Oral Health Program (OHP) and the WV Dental Association to initiate dental clinics for children in the South Eastern region of WV. CSHCN will collaborate with the OHP to survey families of children enrolled in CSHCN concerning access to dental care. The oral health of children with special health care needs is an issue of

increasing importance. CSHCN is collaborating with OMCFH's Oral Health Program (OHP) and the WV Dental Association to develop school-based dental clinics for children in the South Eastern region of WV. Five thousand surveys were sent to families of children enrolled in CSHCN concerning access to dental care. CSHCN staff participated in the Oral/Dental Health Forum held in October 2004.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			59.8	59.8	59.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

According to West Virginia Kids Count 2003, a survey on health insurance coverage completed in December 2003 showed 96.3 percent of all West Virginia children had health care coverage at some point during 2003. Systems Point of Entry (SPE) in OMCFH identifies families that do not have Medicaid, CHIP or private insurance coverage at the time an application is made for CSHCN. Families without resources to pay for medical services are referred to WV CHIP and to WV Medicaid.

During Calender Year 2004, Systems Point of Entry provided the following activities:

1. 790 requests for referral services received:

299 families of children identified on the Birth Defects Registry as having congenital problems received OMCFH program information
402 families identified by the Social Security Administration as approved for Supplemental Security Income (SSI) were offered additional referral services
89 identified by OMCFH Reportable Disease, Newborn Metabolic, Newborn Hearing and Lead Screening Programs

2. 1,583 applications and informational materials distributed as follows:

596 Specialty Care Intake Form (SCIF) for CSHCN applications
42 CHIP applications
17 OBRA applications for Medicaid coverage for pregnancy
928 brochures/pamphlets for patient education and informing were distributed

3. 4,697 telephone inquiries received by the toll-free responders.

During CY 2004, 81.99% of children participating in CSHCN were Medicaid beneficiaries. The increase over last years percentage is attributed to the continuing commitment of CSHCN to assist families to obtain health care financing through assisting with SSI applications, the expedited SSA/Disability Determination process and CHIP/Medicaid applications.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All children/families without insurance coverage are assisted with accessing health care financing through referral to WVCHIP and/or local DHHR county offices.		X		
2. Staff are trained on eligibility requirements for accessing government programs.				X
3. Families are provided guidance as to specific information required to apply for DHHR assistance.		X		
4. Denied Medicaid or CHIP applications with income below 185% FPL are financially eligible for CSHCN.	X			
5. Systems Point of Entry staff maintains current information on available resources.		X		
6. Currently 96.3% of all WV children have health care coverage.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Efforts to increase access for minority participation in CSHCN and other programs within OMCFH were addressed through the establishment of a clinic for the treatment of Sickle Cell in conjunction with Women and Children's Hospital, Charleston, WV. CSHCN provides the social services and nursing component for this clinic.

WV CHIP, CSHCN, Birth to Three, and Right From the Start Programs continued efforts to involve the faith based community in identification and outreach to uninsured and under insured children.

c. Plan for the Coming Year

Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Division of Management Information Systems will identify approved or denied Medicaid beneficiary children (age 0-20)who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail these families information about available CSHCN Program services and care coordination. This will augment population based surveillance efforts and children identified as consequences of an EPSDT screen.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			73.1	73.1	73.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The OMCFH Quality Assurance and Monitoring Unit monitored 309 of the total of the customers' call-in contacts received by System Point of Entry for consumer satisfaction. Approximately 20% of these calls were from families of children with special health care needs. Public response to SPE telephone referral and assistance operation continues to be completely positive. Those contacted stated that they were pleased with how they were treated. None indicated dissatisfaction with the services and guidance received.

Effective January 15, 2004, the Systems Point of Entry Unit began using an electronic format system for collecting information on calls received on the toll-free lines. This eliminated the manual record keeping system. This served to increase the efficiency of record keeping as well as improving access of the OMCFH Quality Assurance and Monitoring Unit to SPE recording for monitoring of customer satisfaction of service provided by the responders.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parents participate in policy and procedures development for WV Birth to Three and CSHCN.		X		
2. Collaboration with WV Medicaid to optimize resources and plan efficient use of funds.				X
3. CSHCN collaborates with other OMCFH programs to coordinate needed services efficiently.		X		
4. CSHCN Medical Director participates on Medicaid policy committee sharing input from families.				X
5. Parents and CSHCN staff take part in statewide mini conferences coordinated by the Parent Network Specialists and funded by contract with CED.		X		
6. CSHCN Program Advisory includes youth, parents and service providers.				X
7.				
8.				
9.				
10.				

b. Current Activities

Representatives from CSHCN participated in the 13th Annual Community Connection Conference held at Canaan Valley Resort, Davis, WV, sponsored by the DHHR Family Support Program. This conference brought together families of children and young adults with special needs to discuss topics such as inclusion in the community, self-determination, stress management, and special education. A presentation concerning program services was given, and the CSHCN display was included in the exhibits at the conference.

The CSHCN quality assurance component was strengthened by implementing an internal process to monitor work of staff as documented in enrolled patient records. Each month the CSHCN Director of Nursing and the Director of Social Services review a portion of each of their staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. This process identifies areas needing improvement and serves as a bases for staff training and evaluation. This system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing and the Director of

Social Services. An electronic data system was developed by OMCFH's Division of Research, Evaluation and Planning for recording and tracking of reviews completed. This allowed the CSHCN nurses and social workers to be more responsive to inquires by the tracking of authorization and delivery of patient equipment.

CSHCN participated with West Virginia University Health Associates at Women and Children's Hospital, Charleston, WV, in the FACES clinic. This clinic is a multi-disciplinary team effort that involves plastic surgery, orthodontia, dentistry, genetics, audiology, social services and speech therapy. CSHCN provides the social work component for a multi-disciplinary team.

In FY 2004, five FACES clinics were held. CSHCN applications were made for 7 of the 37 patients seen by the CSHCN social worker. Home visits were done at the request of the clinic physicians/treatment team for CSHCN enrolled children throughout the state. CSHCN applications were completed for 6 clients.

To better inform families and medical staff of alternatives for care of cystic fibrosis and to provide support for families, CSHCN sponsored a C.F. Family Education Day for children and their parents.

Effective January 15, 2004, the Systems Point of Entry unit began using an electronic format system for collecting information on calls received on the toll-free lines. This eliminated the manual record keeping system. This serves to increase the efficiency of recording keeping as well as improving access of the OMCFH Quality Assurance and Monitoring Unit to recordings for monitoring of customer satisfaction with service provided by the Responders.

To enhance the operation of service systems and encourage community partnerships in the delivery of services, the CSC Director, or designated representatives, serve on multiple committees or advisory boards.

c. Plan for the Coming Year

The parent interest survey already completed by WVU-CED.
A new parent satisfaction with medical community survey.
A survey of enrolled adolescents' and young adults' knowledge and use of transition services.
The oral health survey was completed by the OMCFH Oral Health Program.

Revision of the CSHCN Policy and Procedure Manual was completed February, 2004, and distributed to program staff, DHHR offices, and selected providers in April 2004. All CSHCN forms and correspondence were revised and included in the manual. A complete review of the diagnostic codes for covered medical conditions was done. Program staff and Parent Network Specialists will receive training on new procedures during regional workshops which began June 2004.

In 2004, CSHCN will collaborate with the Bureau for Public Health, Office of Nutrition's Special Supplemental Nutrition Program for Women, Infant, Children (WIC) to expand their services to children with special health care needs. A speaker from CSHCN provided information about CSHCN at two regional conferences for WIC staff entitled Meeting Unique Needs. CSHCN program nurses and social service workers attended the conferences to provide an opportunity for networking and resource development.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6.5	6.5

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Transition services are included as part of the development of the Patient Care Plan completed with youth enrolled in the CSHCN Program. During CY 2004, transition services were provided to 1,256 youth, age 14 and 21. Also CSHCN Program collaborated with the Division of Vocational Rehabilitation. The Division provides staff who are dedicated to transition planning for children with disabilities, using the public school system. There are 59 staff with this assignment statewide with 35 full time equivalents.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Transition services are provided by CSHCN to all program participants.		**X**		
2. CSHCN nurses and social workers receive training in provision of adolescent transition services.				**X**
3. Adolescent Transition Screening Tools were developed for use in care coordination with adolescents and young adults.		**X**		
4. CSHCN expanded services to the adolescent population, including				

transition services for youth 14 to 21 years.		X		
5. Formal relationship is in place with the Department of Education and Division of Rehabilitation to assure children with disabilities receive transition planning.		X		
6. Stipends are provided to youth to participate in self advocacy training.		X		
7.				
8.				
9.				
10.				

b. Current Activities

On August 30 and 31, 2004, the CSHCN Annual Staff Conference focused on personnel development and community resources. The program included presentations by a representative from the Family Resource Center at CAMC (one of WV's 3 tertiary care facilities), OMCFH Adolescent Health Coordinators, a representative from the OMCFH Children's Dentistry Program, a represetative from the OMCFH Birth to Three Program, and a representative from the Make a Wish Foundation.

Written policy concerning delivery of adolescent transition services was expanded in the CSHCN Program manual released to staff in April 2004. This policy places a higher priority than previously on home and other face-to-face contacts for development of Patient/Family Care Plans for youth in transition. Transition screening tools were developed for use with adolescents age 14, 16 and 17; and with young adults ages 18 and 21. The transition services policy was expanded and included in the revised CSHCN Policy and Procedure Manual along with the transition screening tools.

For the first time, adolescents were invited to join the expanded CSHCN Program Advisory to offer the prospective of adolescent consumers and a voice to their concerns. These adolescents receive or have received CSHCN services.

c. Plan for the Coming Year

A greater emphasis will be placed on beginning transition services at age 14 and 16. Youth will be included in their care planning teams and be given more responsibility for treatment compliance. In addition to the reports already produced identifying young adults 18 and 21 years, the CSHCN electronic data system will produce reports to identifyng adolescents 14 and 16 years of age. The feasibility of development of adolescent specialty care clinics for delivery of medical care will continue to be explored. The goal of establishing a CSHCN Youth Advisory will also be explored.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	90	90	90	90	90
Annual Indicator	75.8	82.1	83.4	81.8	79
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	90	90	90

Notes - 2002

2002 immunization data is currently unavailable. May be available in July, 2003.
data source: Immunization registry, Division of Surveillance and Disease Control

Notes - 2003

Data from the WV Immunization Program based on sampling through site visits performing quality assurance assessments.

Notes - 2004

Data from WV KidsCount 2004

a. Last Year's Accomplishments

While still below the targeted performance objective of 90%, as set by Healthy People 2010, the percentage of children being fully immunized by the age of 2 years has increased substantially over time but has been stagnant over the past few years. In 2003, 71.5% had been immunized for DTaP, 89.3% for MMR and 91.9% for Hep B.

The State's Immunization Program is housed in the Office of Epidemiology and Health Promotion's Division of Surveillance and Disease Control. This program works closely with the local health departments, WIC, birthing hospitals, the private practicing medical community, and other early childhood programs in an effort to get children fully immunized.

The EPSDT Program has actively worked to ensure that children participating in the program receive complete immunizations by age 2. The HealthCheck program publicizes the Childhood Immunization Schedule in a HealthCheck Provider Manual that is used by 463 HealthCheck providers. The providers immunize children in accordance with the schedule or they refer their clients for immunizations in accordance with the schedule.
The OMCFH monitoring team monitors the documented immunizations when monitoring HealthCheck pediatric providers.

The Immunization Program conducted a 2004-2005 Immunization Kindergarten School Survey in cooperation with the Department of Education, local Boards of Education, school nurses, principals and secretaries. Sixty schools were randomly selected from the 489 of the 585 responding public and private schools to receive a Validation Audit, which is conducted to verify the accuracy of the school survey as well as monitor the actual immunization records for correct doses, dose intervals and validity. Results showed 85% accuracy according to audit results. Of the 60 schools, the Immunization staff reviewed 2,137 kindergarten records and 69 out-of-state first grade transfer records. Results of the audit revealed: 1.63% (36 students) were missing at least one required immunization; 0.40% (9 students) had invalid doses; 0.27% (6 students) had no records and 2.31% (51 students) were non compliant.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Need for imunizations is promoted by RFTS, WIC and other public health programs.				X
2. The EPSDT Program encourages providers to offer immunizations as part of health care.				X
3. An OMCFH monitoring team monitors the documented immunizations of HealthCheck clients.				X
4. The RFTS Project collects data on whether or not infant participants (who are up to 12 months) are up to date on immunizations.				X
5. All women giving birth in WV receive information at time of discharge about primary care including immunizations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The West Virginia Immunization Program is working to increase the number of providers using the Immunization Registry. Of the 370 providers of immunizations, 165 are currently enrolled with the registry.

A certificate of immunizations has been developed. The Certificate of Immunizations will help improve preschool and school-age immunization levels by establishing a standard process by which children are given documents certifying receipt of age-appropriate immunizations. A uniform Certificate of Immunization will enable the consolidation of all valid immunization dates on one document that can be utilized by schools, child care centers and in other settings. The certificate is a tool used by the Immunization Program as an ongoing effort to increase preschool and school immunization levels in West Virginia.

Exceptions were allowed for children entering West Virginia schools for the first time for the 2002-2003 school year for required shots of diphtheria, tetanus and acellular pertussis (DtaP) and tetanus and diphtheria toxoids (Td) due to the then existing nationwide shortage of these vaccines. Shortages have since been resolved.

c. Plan for the Coming Year

The Office of Maternal, Child and Family Health's responsibility is one of tracking and increasing medical capacity to serve as health homes for children. The Immunization Program interfaces with the Office of Maternal, Child and Family Health in developing public health policy. The OMCFH workforce that provides technical assistance to the medical community on all child health issues also provides guidance on vaccine administration.

The OMCFH maintains a Pediatric Medical Advisory comprised of pediatricians, family practice physicians, dentists, etc. who assist with policy guidance but also serve as spokespersons offering guidance for public health policy. Persons serving in this capacity speak routinely at the West Virginia Chapter of the AAP and AAFP. Using these champions to voice public policy

about immunizations and other child health issues assists the Department with compliance and keeps the medical community engaged in the provision of service.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	21.98	21	21	20	20
Annual Indicator	23.3	21.9	20.7	20.1	19.8
Numerator	813	774	733	711	702
Denominator	34905	35411	35411	35411	35411
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19	19	19	18	18

Notes - 2002

2002 vital statistical data is not available. Provisional data will not be available until Fall,03. data source: WV Health Statistics Center

Notes - 2003

Data from 2002 Vital Statistics based upon the female population ages 15-17.

Notes - 2004

Data from 2003 Vital Statistics based on the female population ages 15 to 17 years

a. Last Year's Accomplishments

Under the administrative direction of the Family Planning Program, the Adolescent Pregnancy Prevention Initiative (APPI) promotes public awareness of adolescent pregnancy prevention and related issues through community education and outreach activities for community groups, schools, health care professionals, parent groups, and businesses.

Community education and outreach activities:
"National Teen Pregnancy Prevention Month" in May 2004
"National Day To Prevent Teen Pregnancy" in May 2004 promoting a onetime interactive quiz created by Teen People and the National Campaign to Prevent Teen Pregnancy
"Mother's Day Too Soon" and "Father's Day Too Soon"campaign. Mailed cards containing information on WV adolescent birth rates and statistics in comparison to United States
Mailed information on "Let's Talk" October 2004 to all WV middle, junior and senior high schools, public libraries and other contacts on the APPI mailing list
Revised and released APPI Fact Sheet April 2004

WV Dept of Education:

Member of State School Board of Education National Healthy Schools network
Lead partner with Department of Education/Office Healthy Schools developing strategic plan for improving prevention services
Office of Student Services and Health Promotion, HIV/AIDS Program

Committees/Task Force/Councils:
The APPI Coordinator and Specialists worked collaboratively with greater than 35 public/private entities which address pregnancy prevention needs of adolescents: (partial listing)
WV Abstinence Only Education Advisory Council
WV School Based Health Assembly
Coalition for WV Children
Region III Teen Pregnancy Prevention Leadership Group
Office of Student Services and Health Promotion, HIV/AIDS Program
Family Resource Networks
Harrison/Marion Tobacco Coalition
Preston County HAPI Consortium
Monongalia County Adolescent Pregnancy Prevention Task Force
PATCH of Marion County
Monongalia County After School for All
Communities of Shalom
Starting Points of Morgan County
Region VIII Adolescent Health Task Force
McDowell Rural Health Advisory Committee
HOPE, McDowell County
IMPACT, Greenbrier County
CAPE, McDowell County
Healthy Communities Access Progress, McDowell County
FACES, McDowell County
Creating Opportunities for Youth, Mercer County
SHAPED, Raleigh County
Youth Enrichment Issues, Fayette County
Bright Beginnings, Wyoming County
Greenbrier Connections Collaborative
Summers/Monroe Wellness Committee

Public Awareness/Speaking and Displaying Opportunities:
153 school presentations (increase from 13 in 2003)
234 school visits
Mailed 318 informational packets to WV schools
4 community presentations
6 parent workshops
Attended 418 community meetings
19 FP Program site visits
Displayed at 22 events
Contributed to 2 newpaper articles and 1 FRN newsletter

Clinical Contraceptive Services:
Offered confidential contraceptive health services through statewide Family Planning Program

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provided confidential contraceptive services through the FP Program to 18,218 sexually active teens in 2004.		X		
2. Recognized and promoted "National Day To Prevent Teen Pregnancy" and "National Teen Pregnancy Prevention Month" (May 2004).			X	
3. Conducted "Mother's Day Too Soon" and Observed "Father's Day Too Soon" campaigns to increase public awareness of the incidence of teen pregnancy in WV.			X	
4. Promoted "Let's Talk" month (October 2004); Free resources to encourage parent/child communication about sexuality.			X	
5. Worked with Dept of Ed/Office of Healthy Schools to develop strategic plan to reduce sexual risk behaviors among students. Presented at 153 WV schools and 4 community presentations and 6 parent workshops on the topic of teen pregnancy prevention.				X
6. Adolescent Pregnancy Prevention Specialist conducted numerous community education and outreach activities on a regional/local level.				X
7.				
8.				
9.				
10.				

b. Current Activities

Adolescent Pregnancy Prevention Initiative:
To carry out the goals and objectives of the Adolescent Pregnancy Prevention Initiative work plan, four (4) permanent full-time personnel were hired to conduct statewide community education and outreach activities on a regional/local level. The specialists are strategically located in community-based settings to have the flexibility of alignment as needs change over time. These 4 Adolescent Pregnancy Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and are developing, expanding or supporting teen pregnancy prevention initiatives on a regional/local level.

Family Planning Program:
Confidential contraceptive services and supplies are available to sexually active adolescents through a network of 145 health care agencies through the statewide Family Planning Program. Participating clinics promote postponement of sexual activity, mechanisms to reduce sexual coercion, and provide counseling to sexually active teens regarding the importance of family involvement in sexual decision-making.

c. Plan for the Coming Year

The Adolescent Pregnancy Prevention Initiative will continue to design and conduct community education and outreach activities to increase public awareness of adolescent pregnancy prevention and related issues for community groups, schools, health care professionals, parent groups, or businesses;
Address state level issues which impact access to or quality of adolescent pregnancy prevention services; confidentiality and parental consent; transportation, financial or other barriers; school health issues; and local availability of pregnancy prevention services.

Educate teens and young adult males on personal sexual responsibility; coordinate community education activities to promote clinical Family Planning Program Services for sexually active teens and those not yet sexually active; conduct presentations and exhibits of educational displays at health fairs, conferences, state fairs, and other public activities; maintain existing and establish new partnerships and initiate referral patterns with entities serving populations of

potential clients; distribute Family Planning Program promotional products, i.e., brochures, posters, fact sheets, etc;

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	50	50	50	50
Annual Indicator	16.1	15.6	22.7	21.3	30.0
Numerator			326	514	1039
Denominator			1435	2413	3466
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	33	33	35	35	38

Notes - 2002

2001 This is estimated based on the number of 3rd grade students screened = 1,652 with 507 having sealants.
2002 This is estimated based on the number of 3rd grade students screened = 3,246 with 854 having sealants.
data source: OMCFH Dental Program

Notes - 2003

Numerators and Denominators for CY 2002 and CY 2003 are taken from the OMCFH Children's Dentistry Project database. It refects the number of 3rd grade students who have been assessed and those that had an observed sealant. The Project covers 28 counties and is a sample representative of the State's population of all 3rd graders. Years 1999, 2000 and 2001 are based on Medicaid sealants only and not reliable.

Notes - 2004

Estimated 2004 data from Children's Dentistry Database. The children's Dentistry Project covers 32 of WV's 55 counties and is being used as representative for the state's 3rd graders. The numerator are those children who were observed to have had a sealant and the denominator are those children assessed.

a. Last Year's Accomplishments

The Children's Dentistry Project (CDP) is a component of the Division of Infant, Child and Adolescent Health and is housed within the OMCFH. Preliminary data for FY 2003 suggests that only 48% of West Virginia Medicaid recipients ages 6-9 received a dental service. In West Virginia, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments adversely affects willingness of dentists to

serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health. The overarching goal of Children's Dentistry is to promote the value of oral health, build service capacity throughout the State by providing technical assistance to providers offering direct care, involve advanced education in developing strategies to address professional shortages, and to improve access using CHIP and Medicaid as the health financing component.

Program highlights were; 1) Fluoride drops and tablets were dispensed through local health departments, WIC offices and at child care sites by health care providers authorized to dispense fluoride, if the child did not have Medicaid or insurance coverage. Medicaid cardholders needing supplements were given prescriptions for local pharmacy use. 2) Recruited and encouraged licensed dentists and hygienists to provide direct program care for CHIP and Medicaid sponsored children. 3) For FY 2003, 42% of children between the age of 3-20, who were Medicaid beneficiaries, received a dental service as compared to 42% in FY 2002. 4) Provided and approved literature for distribution that addresses oral health needs. Literature and program operational guidance were distributed using the Pediatric Program Specialists who routinely visit the medical practitioners' offices, see reference earlier to field staff under EPSDT. 5) Prepared and distributed a listing of all WV dentists serving children, including those accepting Medicaid reimbursement. This list was distributed to all providers of primary care, school nurses and other relevant personnel.

The Children's Dentistry Project also provided literature to the Right From The Start's Regional and Designated Care Coordinators to address dental care for pregnant women and encourage infant teeth care to reduce the incidence of baby bottle tooth decay.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Dentists receive fiscal support from OMCFH to apply sealants.		X		
2. Medicaid and CHIP policy support the application of sealants at urging of OMCFH.				X
3. Program provides preventive guidance regarding oral hygiene and good dental practices.			X	
4. EPSDT provides dental examination and referrals if needed.	X			
5. The Dental Project provides grade-specific oral health education modules to all public schools.			X	X
6. OMCFH is the recognized government entity for oral health care in WV.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CDP currently has 17 contracts with local health departments, primary care facililties, and individuals to offer oral health education to students in public schools. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and

other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. The CDP contracts with local dentists to purchase all supplies, and perform all billing functions. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access.

There are significant numbers of West Virginians who do not have a fluoridated water supply. Some of those receive water from public systems. Fluoridation equipment is inexpensive and supplies are no more than $3. per customer per year. The savings in future dental caries is 5 to 6 times that amount. For example: For a town the size of New Martinsville (currently not receiving fluoridated water), the annual cost of fluoridation would be $35,500. If only one cavity is prevented in an entire family, the net savings for the community is $124,200 annually. The CDP is beginning a project to work with a limited number of local communities and water systems to advocate for fluoridation and to assist communities to be able to obtain fluoridation. A small amount of funding is available to pay for necessary equipment. The Office of Environmental Health Services has been approached as a non-funding partner and is willing to participate. Other funding sources are currently being explored. This infrastructure development will have lasting implications and may be supported through the Governor's Office of Community Development.

c. Plan for the Coming Year

The CDP is continuing to work on a pilot project in McDowell County for a school-based dental clinic. The CDP purchased equipment and supplies for this project. In addition to preventive dental services, students will be provided with oral health education materials and referred to local dentists for restorative care when necessary.
The CDP is also partnering with other Primary Health Care Facilities to offer school-based dental services and oral health education to students inLincoln, Marshall, Jackson, Ritchie and Calhoun counties.

To design effective health promotion campaigns and materials, we must know what the customer is thinking. The CDP is implementing a reserch project in conjunction with higher education to learn more about the attitudes of youth and parents toward dental care, and learn more about the barriers to receiving dental care. To date, 2,359 surveys have been returned and are being processed through data entry.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	4	4	4	3.5
Annual Indicator	9.7	6.1	4.9	4.6	4.3
Numerator	32	20	16	15	14
Denominator	329137	329139	329137	329137	329137
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.5	3.5	3.5	3	3

Notes - 2002

data source: WV Health Statistics Center

Notes - 2003

Numbers from 2002 Vital Statistics

Notes - 2004

from 2003 vital statistics

a. Last Year's Accomplishments

The West Virginia Rehabilitation Center is committed to delivering comprehensive services to people who have sustained traumatic brain injuries. The program includes the following elements:
-Comprehensive evaluation - receive a holistic evaluation by medical professionals who have experience in diagnosing and treating traumatic brain injuries.
-Work activity/vocational training - learn ways to work around the effects of your injury and train or retrain to return to the workforce.
-Life skills training - relearn how to take care of your personal needs and become independent again.
-Behavior management - learn coping skills for dealing with the emotional side of recovery
-Patient/family education - training for patients and family members about caring for people with traumatic brain injuries.

The EPSDT Program provides anticipatory guidance to parents about childhood injury that may result in death. The WV Youth Risk Behavior Survey information for 2003 reports that 20% of WV youth report that they rarely or never use seatbelts. Males were twice as likely not to use seat belts (20%) as females (10%). The State of West Virginia has a mandatory seatbelt law, which was strongly advocated for by the Bureau for Public Health and other medical partners.

The WV Board of Education implemented in 2003 the first statewide assessment of health education efforts. A total of 51 counties and 242 schools participated. The results of the survey identified the need for increasing student's health knowledge.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The EPSDT Program provides anticipatory guidance to parents regarding childhood injuries.			**X**	
2. Adolescent Health Coordinators and others provide classroom injury prevention instruction.			**X**	
3. Oral Health Educators discuss mouthguard usage, etc. in schools.			**X**	
4. Adolescent Health Coordinators developed and distributed information on date rape (violence), bullying, etc.			**X**	
5. Department of Education/Health Education Assessment Project to				**X**

calculate student health knowledge.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The EPSDT Program continues to provide anticipatory guidance to parents about childhood injury that may result in death. The Adolescent Health Initiative also develops teaching tools which encourages the use of helmets as a means of preventing TBI. At the time of discharge, all birthing hospitals in the State issue an infant car seat for those families who do not have/can't afford one. The Adolescent Health Initiative was designed to complement the HealthCheck Program with the expressed purpose of creating awareness among families, and others of the need for young persons between the ages of 10 and 17 to be provided routine health services. Two components of this program include: 1) the provision of educational programs emphasizing preventive services/risk reduction behaviors such as seat belt use and tobacco/alcohol use; and 2) development of teaching modules that can be used in community-based training designed to improve the health and well-being of adolescents and their families. The Adolescent Health Initiative (AHI) staff are supported with Title V monies but physically housed and hired by community-based partnership organizations.

c. Plan for the Coming Year

The community-based workforce that administers our Abstinence Only Education Program and another group of partners who administer the Adolescent Health Initiative all work to address the issue of health behaviors. Not every motor vehicle accident is alcohol related but our data tells us many of them are. The Adolescent Health Initiative offers parent/child communication skill building, community development activities that include plans for safe recreation after prom, etc. Helping families to talk with their children about risk behaviors is an essential part of effecting change. The Abstinence Only Effort is focused on a much younger population with the same emphasis about abstaining from alcohol and other risk behaviors. Legislation has passed in WV requiring helmets and seatbelt use. In 2004 the Legislature approved ATV laws requiring the use of helmets. We continue work with Transportation and Traffic Safety to develop materials that are directed to youth. We also are using our existing workforce and partnership network for distribution of this anticipatory guidance.

Continue to support the Department of Education efforts to improve health education instruction in public schools designed to positively affect health and health related decision making.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	41	55	55	55	57

Objective					
Annual Indicator	53.5	55	55.5	55.5	56
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57	57	58	58	58

Notes - 2002

PRAMS data nor Vital Statistics data is available for 2001. Should be available in late summer or early fall.
data source: PRAMS

Notes - 2003

Statistics obtained through PRAMS information. PRAMS information is not available for 2002 or 2003 yet. 2002 data should be availale in the summer of 2004. 2002 and 2003 data are estimates at this time. PRAMS data is based on weighted sample information.

Notes - 2004

Statistics obtained thru PRAMS information. PRAMS information is not available for 2003/2004. 2003 data may be available Summer of 2005. 2003/2004 are estimates at this time. PRAMS data is based on weighted sample information.

a. Last Year's Accomplishments

The 2004-2005 Office of Nutrition Service Breastfeeding Initiatives included: 1) Expansion of the WIC Breastfeeding Peer Counselors Services; 2) Elevated staff knowledge so that all WIC staff positions are confident in promoting and supporting breastfeeding by providing a two day training for all clerical, medical and nutritionists; 3) Ensured program expansion by dedicated planning time for breastfeeding services; and 4) Enhanced breastfeeding support services by collaborating with physician practices.

West Virginia was one of the 10 states nationwide that received a two-year grant, called "Using Loving Support to Build a Breastfeeding Friendly Community" covering the fiscal year 2004-2005. Technical assistance follow-up visits were made, the purpose of these visits was for assistance and other training opportunities to be given to states by trainers from Best Start Social Marketing. Projects involved will enable the West Virginia WIC program to increase breastfeeding initiation and duration rates in nine rural counties in southern West Virginia where there are low breastfeeding rates but growing community awareness and support. For example TSN WIC program elected to have training at three major labor and delivery hospitals and local health clinics to better prepare health professionals for the first few days of supporting breastfeeding families. Also, Best Start billboards through Magic Media (billboard rental company) were purchased and put up in Mingo and Logan counties for 3-4 months. The purpose in these counties are due to low breastfeeding rates and negative attitudes towards breastfeeding.

The Office of Nutrition Service, WIC program also received funding for Fiscal Year 2005 Operational Assistance Funds to provide the purchasing of the following: books and posters to distribute to health care providers, baby scales that measure the amount of breastmilk the infant ingests, banner stands to promote breastfeeding for outreach events and to loan to health care providers, hiring minority peer counselors and providing salaries for lactation

consultants and peer counselors to visit hospitals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All women participants in the OMCFH programs receive benefits of breastfeeding information.		X		
2. The WIC Program strongly supports and promotes breastfeeding.		X		
3. RFTS collects data on prenatals who are breastfeeding at hospital discharge, and how many continue to breastfeed at case closure.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

While the latest data on breastfeeding indicates that a low percentage of women chose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular , the Office of Maternal, Child and Family Health. All pregnant women participating in the Office of Maternal, Child and Family Health's Right From The Start Project receive information about the benefits of breastfeeding their infants. Further, the Bureau for Public Health participates in all national breastfeeding media campaigns.

In addition, the State's Office of Nutrition Services, which administers the WIC Program, promotes breastfeeding and has on staff a Lactation Specialist. As stated previously, all pregnant women participating in Right From The Start, the State's Perinatal Program, or identified to public health, are referred to WIC.

c. Plan for the Coming Year

WIC's goals for nutrition education services for 2005-2006 include: 1) Providing breastfeeding information and education to all pregnant AC participants and health care professionals which promotes breastfeeding in order to increase the number of babies who are fed breastmilk. 2) Provide post-partum breastfeeding assistance and support which promotes continued breastfeeding throughout the first year of life. Preliminary data indicates that 22.4 of women who initiate breastfeeding are continuing to breastfeed for 6 months or longer. 3) Provide additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physician practices in order to keep mother's breastfeeding longer.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95	95	97	97	98
Annual Indicator	84.6	95.5	96.7	97.7	98.2
Numerator	18285	20047	20435	20993	18868
Denominator	21616	21001	21133	21480	19222
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.5	98.5	98.7	99	99

Notes - 2002

data source: West Virginia University who administers the collection of data for the OMCFH Newborn Hearing Program

Notes - 2003

Statistics from West Virginia Universtiy Birth Score Program that collects the Birth Score information for high risk infants and Hearing screens from the birthing hospitals.

Notes - 2004

Statistics from WV University BIrth Score Program

a. Last Year's Accomplishments

Significant progress has been made in achieving the goals set forth by the WV Newborn Hearing Screening Project (NHSP) since its inception. In calendar year 2004, the occurrence births were 21,272, with 98% being screened before discharge. Three percent of the screened infants failed their screen, and were referred for follow-up. West Virginia birthing facilities have been consistent in completing hearing screens and providing opportunities for infants who are missed in the hospital.

In calendar year 2003, the NHS Project provided follow-up on 1,028 resident infants (446 not screened and 582 failed). Those who were diagnosed with hearing loss were referred to the WV Birth to Three Program for early intervention services, the Ski*Hi Parent/Child Program for home-based family education and support for deaf and hard of hearing children and their families, and/or the Children with Special Health Care Needs (CSHCN) Program to facilitate diagnostic evaluation and clinical intervention, which may include hearing amplification.

In the recent past, NHS purchased four portable otoacoustical emissions (OAE) screeners for use by birthing facilities when their equipment is temporarily down. Not only birthing hospitals, but the NHS/RFTS coordinators have shown a positive response to this purchase. Each infant that is not screened due to equipment failure in the hospital is referred to a Designated Car Coordinator who tracks the infant. The loaner equipment helps to reduce these extra expenses and time delays.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All WV birthing facilities are screening infants for hearing loss.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program.		X		
3. OMCFH maintains loaner equipment and shared hospital home equipment for care.				X
4. OMCFH purchasing diagnostic equipment to assure access/availability.			X	
5. Redesign monitoring tool to better meet Program needs.				X
6. Redesign and update NHS website.				X
7. Create informative literature for providers and parents.				X
8. Recruit new Advisory Board members per WV state code.				X
9.				
10.				

b. Current Activities

The NHS Project continues to focus on improving access to timely audiological diagnosis and intervention. Four regional diagnostic centers will be provided with state-of-the-art equipment. Services that will be available include the ability to analyze hearing response and digital hearing aids without having to rely on voluntary responses, otoacoustic emission (OAE) and auditory brainstem response (ABR) screeners for use in neonatal intensive care units and as a backup to failed hospital screens, and high frequency tympanometry to assess middle ear function.

Additionally, birthing hospitals are provided with Newborn Hearing Screening information and education from the Birth Score Office. Audiology Services Availability and Reference Manuals and NHS brochures are continuing to be distributed to providers and audiologists by NHS in order to assist practitioners in directing infants and their families to appropriate hearing evaluation and intervention. The NHS Project also sends informative brochures to the parents of infants who were not screened in the hospital or those who were screened and failed.

The NHS Project is also currently planning the creation of a database and new processes that will enhance data collection. With detailed data collection and information sharing, follow-up of infants who either failed or were not screened will be greatly improved. Not only will infants be tracked 100%, but outcomes of the tracking will reveal problems within the system. Solutions to these problems will help to streamline the entire referral process. Some effects of the improved framework will be electronic reporting; less money spent for manpower, repetitive actions, faxing, mailing, and printing; fewer entities receiving identical paperwork; and immediate correction of any errors on the follow-up tracking forms.

Further, the database will be a supportive monitoring tool. Although an actual monitoring tool will be updated and implemented for the Health Facilities Surveyor to use during site visits, the database will identify difficult areas as well as problem providers. The database will be fully operational in the upcoming year.

West Virginia's newborn hearing screening efforts have been recognized by the World Council on Hearing Health, formerly the National Campaign for Hearing Health, with a grade of "excellent" on the published State report card for the past four years, 2001-2004. In part, the

NHS Project maintains a high level of success through its outreach to the health community. One informative resource is the Advisory Board, which is in the process of being refreshed with enthusiastic members of the community per the WV State Code.

c. Plan for the Coming Year

The NHS Project will primarily focus on undetected hearing loss delays speech, language and cognitive development. West Virginia needs to assure timely, appropriate follow up diagnostic services and interventions. West Virginia continues to refine and implement statewide data management and program evaluation.

Goal 1: 100% of newborns born in West Virginia will be screened prior to discharge or within the first month of age.
Objective 1: Assure that all 36 birthing facilities have two trained staff competent in screening and referral protocols.
Objective 2: Assure that a minimum of 90% of WV resident infants born in hospitals bordering WV continue to be tracked via the Birth Scoring System and Vital Statistics and/or data sharing agreements and referred for services when indicated.
Objective 3: Assure that WV resident infants born at home will receive follow up for screening.

Goal 2: 100% of infants requiring audiological follow up and/or intervention will receive a diagnostic evaluation by 3 months of age and receive intervention services by 6 months of age.
Objective 1: Assure that a minimum of 80% of all PCP/Medical Home from each of eight service regions are properly trained to increase knowledge, understanding, and facilitation of appropriate follow up and intervention.
Objective 2: Improve NHSP follow-up to assure an appropriate, timely audiological evaluation and intervention.

Goal 3: 100% of infants referred from screening will receive follow up and an audiological evaluation by a qualified provider.
Objective 1: Assure that one audiologist in each of the eight service regions is trained to provide diagnostic follow up and select/fit appropriate amplification.
Objective 2: Identify and recruit additional medical providers to improve the availability of diagnostic testing for infants who fail the screen.

Goal 4: Continue to assess resources to assure that 100% of children with hearing loss and their families are linked to community-based, culturally competent support systems.
Objective 1: Maintain a training level of at least 90% of the early intervention specialists and coordinators to address intervention with children with hearing loss.
Objective 2: Parent information, letters, brochures and resource guides will be updated and created in English and Spanish.
Objective 3: Assure that 100% of children with hearing loss and their families will be referred for early intervention and with parent-to-parent networks.
Objective 4: A Service Guide will be updated and distributed quarterly and a web based resource directory will be developed.

Goal 5: Continue to provide monitoring, evaluation, and quality assurance reports.
Objective 1: Produce quality comprehensive data reports and conduct program monitoring and evaluation quarterly and annually.
Objective 2: Continue data linking efforts enabling individual tracking and assurance of follow-up care through the creation of a user-friendly database.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	5	5	5	5	5
Annual Indicator	12.0	6.6	6.1	6.1	5.6
Numerator	51341.8	28233	26213	26011	24025
Denominator	427849	427879	427879	427879	427879
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	4.8	4.8	4.8	4.8

Notes - 2002

data source: WV Kids Count

Notes - 2003

Information from CHIP.

a. Last Year's Accomplishments

The Children's Report from the West Virginia Healthcare Survey contains very good news, since a substantial number of our children (93.4%) have health insurance coverage. On any given day, an estimated 6.6 percent of West Virginia's children (28,371) are uninsured. However, there are several notes of caution in this report. First, an additional 6.6 percent of the State's children are estimated to have insurance that pays only for catastrophic health care costs and so are classified as underinsured. Second, about 14 percent (59,699) of children were uninsured for some period of time during 2001.

While about 62.2 percent of insured children are covered through a parent's employment-based or family-purchased health insurance program, nearly a third of West Virginia children are insured by the State's public health insurance programs-Medicaid and CHIP. The survey's estimate of the number of uninsured children give the State's decision-makers a better target for additional outreach and enrollment efforts, since the survey indicates that a little over 74 percent of uninsured children may be eligible for Medicaid or CHIP on the basis of their family's income. The finding that parents of 31 percent of children who may be eligible for the CHIP program and 20 percent of those who may be eligible for Medicaid have never heard of these programs is notable. The survey indicates that nearly 80 percent of uninsured children are between the ages of 6 and 18 years old, a finding that is significant to the State's policymakers as they address the problem of providing insurance coverage for all children.

The Survey provides very good news about West Virginia children's access to health care services. About 93 percent have a usual source of care, mainly at a physician's office or at community and other local health clinics, and about 89 percent of those see the same physician when they go for care. Approximately 96 percent of parents, asked if their child was able to receive needed medical care during the past year, responded in the affirmative. It is not surprising that for 52.6 percent of the children who did not get needed medical care during

2001, the main reason was cost.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All children referred to OMCFH programs are assessed for eligibility for Medicaid, CHIP or Title V.		X		
2. The Systems Point of Entry Project (SPE) within OMCFH provides CHIP applications to families.		X		
3. The SPE assists with OBRA applications for Medicaid coverage for pregnancy.		X		
4. Medicaid and CHIP have resulted in more WV children having access to health coverage.		X		
5. CHIP applications are routinely distributed by EPSDT staff during provider site visits.		X		
6. CHIP is continuous for a one year eligibility.		X		
7.				
8.				
9.				
10.				

b. Current Activities

CHIP enrollment, as of April, 2004, now covers 24,400 children and has expanded to 200% of the Poverty Level. The goal is to cover the additional children believed to be eligible for CHIP. CHIP has partnered with clinics across the state encouraging them to distribute applications for CHIP. The WV Primary Care Association received fiscal support to provide community-based outreach for CHIP statewide. Children's Specialty Care, Systems Point of Entry mailed out CHIP applications during FY 2004.

The Pediatric Program Specialist, as a part of EPSDT, administered by OMCFH, routinely distributes CHIP applications when visiting medical practioner sites serving children.

c. Plan for the Coming Year

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 93 percent of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. For the last four years, the WV Healthy Kids Coalition has conducted community-based outreach on CHIP and Medicaid through the placement of outreach coordinators who serve each of the state's 55 counties from 49 locations. Since the inception of this program, more than 40,000 children have been enrolled in CHIP and more than 5,000 children have been enrolled in Medicaid via the CHIP application. To maintain and even improve upon this high level of enrollment we must continue this effective outreach and enrollment effort and explore the recommendations from advocate group for affordable health coverage.

Given the above, our issues are assuring that the state has sufficient medical capacity to meet the demand and secondly, creating a demand for care by educating would-be consumers on

the importance of receiving basic primary, preventive health care. In order to determine why patients aren't using the health services now that they have health care financing, we plan to survey families and providers about issues of accessing care.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	80	80	85	99
Annual Indicator	98.6	98.7	98.5	98.9	98.9
Numerator	197711	197672	205905	214154	214150
Denominator	200525	200205	208997	216516	216516
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

Notes - 2002

data source: Medicaid Claims on the HCFA 416 Report; Medicaid Births/Vital Statistics

Notes - 2003

Statistics from the Medicaid Program based on paid claims

a. Last Year's Accomplishments

The proportion of eligible children receiving a service from Medicaid has ranged over the past several years from a low of 53 percent in 1997 to a high, in 2002, of 95 percent. The EPSDT Program, administered by the Office of Maternal, Child and Family Health, provides dedicated outreach to eligibles in order to encourage participation.
The OMCFH administers the EPSDT Program, and uses the outreach requirement of the federal legislation to encourage families with children to participate in routine, primary preventive care. The total number of technical assistance trainings face-to-face with the medical community was 1,788 in FY 2004.

Infants whose birth was sponsored by Medicaid and served by RFTS was 36% of all Medicaid sponsored births. Approximately 57% of all state births were to Medicaid sponsored women, and all infants born to mothers with Medicaid coverage are eligible for Medicaid for the first year of life. The EPSDT program also works closely with the Office of Social Services in assuring that all children in State custody receive an EPSDT screen within thirty (30) days of placement.

Medicaid beneficiaries with chronic dibilitating conditions represent 80% of children in the

CSHCN Program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH administers the EPSDT Program.				X
2. The EPSDT Program provides dedicated outreach workers to encourage participation.		X		
3. Approximately 57% of all births in WV are sponsored by Medicaid covering the infant for a year.		X		
4. The EPSDT works closely with the Office of Social Services to assure EPSDT screens for kids in State custody.		X		
5. Children in State custody receive a screen within thirty days of placement.	X			
6. 80% children participating in CSHCN Program have insurance, CHIP or Medicaid.		X		
7. Number of children seen at school based clinics increased.		X		
8.				
9.				
10.				

b. Current Activities

HealthCheck is West Virginia's name for the mandated pediatric Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in West Virginia have been eligible to participate in the HealthCheck program for the past three years. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exams free of charge.

Pediatric Program Specialists recruit, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional providers for under served areas. The Pediatric Program has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The School-Based Health Center Initiative's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems.

During the 2003-2004 school year, there were 63,567 student visits to school-based health services during the day. 17,241 or 75% of the students in schools with a school-based health center had parental consent to receive services from their centers. Sixty-four (64) percent of

enrolled students used their school-based health center on at least one occasion during the school year. The centers provided access to 1,484 uninsured children, 4,493 children covered by Medicaid, 818 children covered by WV CHIP , and 5,544 children covered by private insurance.

c. Plan for the Coming Year

Our goal is to have sufficient resources to meet the medical needs of the state's children. This means we are constantly recruiting licensed medical practitioners to serve children who have health care sponsored by Title XXI or XIX. This fits well into our plan for all the children to have a medical home, but it also means we must constantly monitor the provider community for medical practitioner and child ratios to assure that any one physician is not becoming overloaded. This is particularly important now that part of the state is involved in Medicaid Managed Care. The practitioner community; that is the managed care provider network, and the people who do government sponsored health care are all one and the same. This state has a limited number of physicians available to provide services. In areas where there are professional medical shortages, we work with the Primary Care Association and the Bureau's Recruitment and Retention Division to have these needs addressed.

The state is fortunate to have over 600 licensed practicing dentists willing to serve children who are Medicaid beneficiaries. We are advocating for the primary care provider/medical home of the child to routinely make referrals to the dentists in the area to assure that the children's oral health needs are met. The state only has 871 licensed practicing dentists and we continue to recruit more to care for CHIP and Medicaid beneficiaries. Forty-eight percent of the Medicaid children between the ages of 6 and 9 received oral health services in 2003. All the children under the age of 3 have access to nursing bottle mouth and other anticipatory guidance which is routinely distributed to parents. Given that a significant number of the state's children have access to medical services, the question we want to answer in the future is "why aren't they using it?". This is especially important in oral health and we are in the process of developing a survey that will be used for youth between the ages of 6 and 20.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.5	1.6	1.7	1.4	1.3
Numerator	318	332	349	288	275
Denominator	20860	20430	20683	20986	20986
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	1	1	1	0.9	0.9

Notes - 2002

Vital Statistics data unavailable for 2002 data
data source: WV Health Statistics Center

Notes - 2003

2002 and 2003 data based on the number of live births with known birthweights from Vital Statistics Division

Notes - 2004

based on 2003 WV Vital Statistics

a. Last Year's Accomplishments

While the proportion of very low birth weight live births is higher than the objective set by Healthy People 2010, the proportion is still relatively low. The Office of Maternal, Child and Family Health's perinatal program, Right From The Start, provides pregnancy risk assessments, called Pregnancy Risk Survey Instrument (PRSI), for all income eligible pregnant women. The risk assessments, as well as additional enhanced services, identify and then attempt to educate all pregnant women identified as being at-risk for poor pregnancy outcomes. Pregnant women are routinely referred to WIC and receive in-home nutrition support provided by RFTS community-based personnel. Personnel providing RFTS are licensed social workers or registered nurses.

In 2003, there were 288 (1.4%) very low birth weight babies born in the state. West Virginia data confirms that very low birthweight infants are born to younger women, the population that we are focusing on through abstinence education, teen pregnancy prevention, and adolescent asset building.

Birthweight data, by smoking mothers, also confirms a West Virginia problem. Over one-fourth (26.2%) of the births in 2003 were to mothers who smoked during pregnancy. While the national figures show 11.0% of women smoked during pregnancy.

The Office of Maternal, Child, and Family Health (OMCFH) of the West Virginia Department of Health and Human Resources (WVDHHR) and West Virginia University (WVU) have finalized a contract and have initiated the Risk Reduction Through Focus on Family Well-Being (HAPI-Helping Appalachian Parents and Infants) Project Healthy Start Grant into the already existing Right From The Start (RFTS) Project of Region VII. Several providers including mental health providers have signed contracts and are participating in the program to provide patient services. The services encompass the RFTS care coordination services provided to eligible pregnant women and infants as per the existing RFTS Project but will expand services to include the preconception phase as well. The HAPI Project focuses on helping women to become healthier before becoming pregnant, encourages spacing of pregnancies, and focuses on mental health issues. In 2003, HAPI Project added child care reimbursement to the list of services offered to women when they attend their medical appointments. OMCFH, as the subcontractor, has established billing procedures and is currently processing patient services invoices. The long-term goal of the project is to decrease the incidence of low birth weight in WV by reducing recurrent low birth weight. It is our hope that the resulting data from this Project may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. OMCFH participates in the low-birthweight education planning for the annual Summits.				X
2. The Right From the Start Program addresses smoking and nutrition issues for pregnant women. ('SCRIPT')		X		
3. OMCFH partners with community health organizations to improve public education efforts.		X		
4. RFTS collects info on the number of very low, low, and normal birth weights.			X	
5. RFTS-HAPI patients receive information on preterm labor detection.		X		
6. RFTS-HAPI clients are referred to WIC.		X		
7. RFTS trains nurses on dental health issues.				X
8. WV Medicaid and PEIA maintain smoking quit lines.		X		
9.				
10.				

b. Current Activities

The high incidence of low birthweight is concentrated in a small number of counties. Activities to address this include Right From The Start follow-up to discuss nutrition during pregnancy and enrollment in WIC.

The Perinatal and Women's Services unit has five staff persons solely dedicated to teen pregnancy prevention efforts, as referenced earlier. These efforts include sex education/instruction in partnership with public schools. Planning and spacing for pregnancy seems to be the key to reducing low birth weight incidence.

The Smoking Cessation Program developed by Dr. Richard Windsor was implemented in West Virginia in January 2002 through the Office of Maternal, Child, and Family Health. It was incorporated into the Right From The Start (RFTS) Project and is now known as "The West Virginia Right From The Start 'SCRIPT'.

Our goal is that following full program implementation, Right From the Start will see a reduction in the rate of pregnant smokers participating in the program. The Tobacco Prevention Program education materials and curriculum was purchased to assure that smoking cessation efforts in WV are supportable through research and are considered best practice methods. It is hoped that the implementation of tobacco dependence treatment initiatives will result in improvement for the overall health of individuals, families and infants in West Virginia, and that there will be a considerate reduction in infant mortality and low birth weight incidence.

c. Plan for the Coming Year

To address identified needs:

Address the barriers for early referral such as transportation, education to women's groups and families stressing the need for early prenatal care.

Continue the education of Designated Care Coordinators stressing the importance of documentation of their efforts to facilitate accurate data collection to be used for comparison.

Continue efforts to educate Designated Care Coordinators in the proper method of using the tools that will enhance support for mothers desiring to quit or reduce smoking by facilitating a

therapeutic relationship between nurse and client.

Continue to build relationships among care providers to assist in identification of women requiring referral into the program.

Provide intense education by RFTS Project providers during the prenatal period about risk factors in contributing to low birthweight infants.

The RFTS Project will take a closer look at the education of families to ensure understanding of the importance prenatal care.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8	8	8	7	6
Annual Indicator	11.1	6.4	15.1	7.2	6.4
Numerator	14	8	19	9	8
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	5.5	5.5	5.5	5.5

Notes - 2002

data source: WV Health Statistics Center

Notes - 2003

Statistics from Vital Statistics2002.

Notes - 2004

data from WV Vital Statistics 2003

a. Last Year's Accomplishments

In 2003, WV had 278 suicides. Suicide was the 2nd leading cause of death in 15-24 year olds at a total of 36, 31 males and 5 females. For the 10-14 year olds, there was a total of 3 suicides.

The Office of Maternal, Child and Family Health's Adolescent Health Initiative provides, through the Adolescent Health Coordinators located throughout the State, increased awareness of adolescent at-risk behaviors leading to injury, disease and death. These Coordinators provide technical assistance to youth leaders and school teachers. Among these at-risk behaviors are

those which can lead to suicide. The Coordinators' work activities involve programs and services to reduce adolescent at-risk behavior.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's Adolescent Health Initiative provides awareness of adolescent at-risk behaviors.		X		
2. In FY 2004, 26 out of the 47 school-based health centers offered mental health services		X		
3. Children's Mental Health has adopted the Columbia Teen Screening to identify suicide risk.		X		
4. The EPSDT screen contains a behavior assessment instrument used for age 10 and above.		X		
5. In FY 2004, visits to the school-based health center therapist accounted for 13% of all visits.		X		
6. In FY 2004, 1,394 students received mental health counseling at 6.3 visits per user.		X		
7. In FY 2004, 53% of the needs addressed were for depression and anxiety.		X		
8.				
9.				
10.				

b. Current Activities

The Department of Health and Human Resources, Office of Community Health Systems received a grant that will support the development of mental health services for children through their primary care center network.

The state has 13 comprehensive behavioral health centers (mental health) available to provide services for the population identified as in need of mental health services. The comprehensives served 695 children in 9 months, all with substantial impairments. The EPSDT screen contains a behavior assessment instrument used for the populations above age 10 years, and serves as a referral, early identification resource.

For the school year 2003-2004, twenty-six (26) of the thirty-seven (37) School-Based Health Centers offered behavioral health services to forty-seven (47) schools. There were 8,782 behavioral health visits by 1,394 students. Depression accounted for 33% of the counseling visits and anxiety 20%. The average number of visits per user was 6.3. The nation is facing a public crisis in mental healthcare for infants, children, and adolescents. One in ten children and adolescents nationally, suffer from mental illness severe enough to cause impairment. Yet in any given year...about one in five of such children receive specialty mental health services.

c. Plan for the Coming Year

West Virginia was one of three states chosen to participate in the Preventive Services Improvement Initiative (PSII)-a national program to improve the quality of preventive services in school based health centers. Representatives from five (5) teams in WV attended. Based on

improvements demonstrated by these five teams, the goals have now been adopted as priorities for all of West Virginia's SBHCs: 1) Increasing the number of comprehensive physical exams, 2) Implementing a system of annual risk assessments, and 3) Improving their clinical and systems practices for intervention, referral, and follow-up.

The Adolescent Health Initiative is a special program, financed solely by Title V, that addresses the most prevalent health risks facing adolescents today by empowering communities and supporting efforts that build resiliency and strengthen families. Our mission is to communicate to all West Virginians that all youth need to be surrounded with networks of individuals and institutions that provide them with support, opportunities, boundaries, and structure. This research-based approach, developed by the SEARCH Institute, has demonstrated these types of efforts increase the likelihood of our youth being empowered to develop commitments, values, competencies, and a positive identity needed to mature into healthy and competent adults.
The primary goal of the Adolescent Health Initiative is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of West Virginia.

In the coming year, the Adolescent Health Initiative will support the efforts of the Adolescent Health Coordinators to build or support existing community asset teams throughout the State. Adolescent Health Coordinators will lend their services to School Based Health Centers to support the Preventitive Services Improvement Initiative.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	80.5	82.6	75.1	84.0	83.3
Numerator	256	257	262	242	240
Denominator	318	311	349	288	288
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	85.5	85.5	85.5

Notes - 2002

data source: WV Health Statistics Center

Notes - 2003

Statistics from Vital Statistics 2002. Based upon the number of live births with known

birthweights born at facilities for high-risk deliveries. This also includes both residents and nonresidents.

Notes - 2004

data from 2003 Vital Statistics

a. Last Year's Accomplishments

The ultimate goals of Right From the Start are to reduce infant mortality and morbidity, increase birth weight, increase access to prenatal and delivery care that meets nationally recognized standards, increase parenthood preparedness, and to foster home environments that are conducive to healthy childrearing. Besides the above listed activities OMCFH also offers a toll-free phone line statewide for referral, and to assist with any questions or problems that patients may encounter.

The Access to Rural Transportation (ART) Project, in conjunction with the Office of Family Support, Non-Emergency Medical Transportation Program, administers a statewide system to provide transportation dollars to low income infants and pregnant women prior to the actual medical encounter to ensure access to "medically necessary" care. There was a total of 9,082 participants who received prenatal and infant services under the RFTS Project.

RFTS data from October-December 2003, shows that the average birth weight for infants born to pregnant women who participated in care coordination services was 6.6 lbs. There were only 2.1% very low birth weight infants born to pregnant participants, 7.4% low birth weight, (23.3% were not reported). The average gestation for a pregnant RFTS client during October-December 2003 was 38.3 weeks.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's perinatal program, Right From The Start (RFTS) serving Title XIX and Title V sponsored provides pregnancy risk assessments.		X		
2. OMCFH advocates that all pregnant women to be screened for medical risk conditions.			X	
3. OMCFH fiscally supports training teams to encourage early screening and referral.				X
4. The WV RFTS 'SCRIPT' educates, supports, and assists pregnant women to quit or lower # cigarettes per day.		X		
5. RFTS case managers educate women on health behaviors that contribute to low birth weight and/or prematurity.		X		
6. RFTS protocols support high risk patient deliveries at tertiary care.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Maternal, Child and Family Health's perinatal program, Right From The Start Project, provides pregnancy risk assessments for all government sponsored pregnant women. Early identification efforts have resulted in increased numbers of very low birth weight infants

being delivered at the State's tertiary care facilities. The Office of Maternal, Child and Family Health staff has repeatedly urged all pregnant women, regardless of income, to be risk screened. This has involved meetings with PEIA and the Insurance Commissioner.
The lack of birthing facilities in every county creates a reluctance on the part of the State's tertiary care facilities to take marginal risk patients; yet it is impossible to predict every high risk patient/condition.

c. Plan for the Coming Year

Since the 1980's the medical community has been screening prenatal patients to determine those who are at risk. The screening involves not only medical screening but also socio-economic issues as well. Because WV's health network is predominantly small community hospitals, the relationships between the community medical provider and the tertiary care provider is important. In recognition of this, two of WV's Schools of Medicine, Departments of OB/Gyn serve as expert resources. They maintain ob hotlines so that the physicians in the communities can call in for case consultation. There is also the use of telemedicine, called MDTV. This allows at risk women to be cared for in their home community by a family practice physician with assistance from the Schools. If the patient is medically high risk, the physician at the local community may still provide some limited care for the patient with intermittent visits to the OB/Gyn in the geographical service area. Extremely high risk women would have their deliveries at the tertiary care facility and this would be pre-arranged. So while a community physician may have taken care of a patient to a point, there would intermittent visits with the OB/Gyn at the tertiary care center who would be doing the actual delivery. To assist the patient, there have been maps developed and opportunity to tour the tertiary care facility to become acquainted with the hospital. This is particularly important in WV given our geographical terrain. When the patient is there we also use this time to do her pre-registration. In an ideal situation, an extremely high risk patient might receive all of her prenatal care at the tertiary care site, but being realistic, this sharing of patient care has worked for us for more than 20 years.
We also have supported and facilitated working relationships between the family practitioners who offer ob services and community based ob/gyns. The process is very similar to the one described above, the exception being the ob/gyn in the local community supports his medical colleague through the care of a patient that is at moderate risk. In this instance, the patient may be able to deliver in a community hospital with the ob/gyn serving as the practitioner. These decisions are precipitated by medical indicators. Because we are sensitive to the state's geography, we've tried to think of every contingency including offering transportation monies to the pregnant woman to allow her to make these travel accommodations. Our RFTS network provides teaching instruction so that the woman will know when she is in labor and who to call in the event of an emergency.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	87	87	87	88
Annual Indicator	82.0	83.0	86.0	85.8	86.5

Numerator	17112	16963	17271	17474	17500
Denominator	20860	20430	20081	20368	20220
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	89	89	90	90

Notes - 2002

Vital Statistics data is unavailable for 2002
data source: WV Health Statistics Center

Notes - 2003

2003 data based on number of of live births with known onset of prenatal care. Data from the Vital Statistics Division. PRAMS data is also used but it is unavailable for 2003 at this time.

Notes - 2004

Estimated on provisional data from Vital Statistics. PRAMS data also used but not available for 2003/2004

a. Last Year's Accomplishments

To increase the number of women receiving prenatal care during their first trimester of pregnancy, the Office of Maternal, Child and Family Health's Right From The Start Project provides comprehensive perinatal services to low income women, including direct financial assistance for adolescents and non-citizens who are ineligible for Medicaid, but whose income is equal to or less than 185 percent of the Federal Poverty Level; limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit and initial laboratory services. Adolescents age 19 years and under are automatically eligible for financial assistance under Title V for medically indigent prenatal services regardless of income. In 2003, 5,652 prenatals enrolled in RFTS.

Because low income women are less likely to seek prenatal care for obvious reasons, we have instituted the following: 1) free pregnancy testing at 153 sites statewide; 2) a Power Point presentation has been presented that discusses the importance of prenatal care and has been used to train the Department of Health and Human Resources eligibility workforce to assure that as they identify potential eligibles, they are referred for services; and 3) the perinatal workforce (Right From The Start) routinely does outreach in the community and has run newspaper ads, done public presentations, and other mechanisms that are targeted toward pregnant women and the availability of service.

The OMCFH works in concert with the West Virginia Chapter of the March of Dimes to ensure information about the need for early and continuous care is provided throughout the State. This partnership supports a population-wide education effort. The OMCFH also works with the Tobacco Prevention Project to train staff, providers, and consumers about the effects of cigarette smoking on pregnancy an infants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Free pregnancy testing is available at 145+ sites statewide.			X	
2. Women who have a positive pregnancy test are assisted with securing health care coverage.		X		
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance.		X		
4. Early prenatal care is strongly encouraged and supported through all family planning efforts.		X		
5. The OMCFH partners with The March of Dimes to provide education targeting early prenatal care.			X	
6. The OMCFH supports efforts to develop capacity in physician shortage areas.				X
7. The OMCFH partners with Health Promotion, Tobacco Prevention Project, to educate and support pregnant women in smoking cessation and/or reduction.		X		
8. The OMCFH partners with the local DHHRs to encourage them to refer pregnant women who are denied Medicaid coverage. for obstetrical care services consideration.		X		
9.				
10.				

b. Current Activities

The Family Planning Program provides free pregnancy testing at all sites in an effort to improve early identification and referral of pregnant women into care. Women who have positive pregnancy tests completed at one of our 145 sites statewide are immediately assisted with completing a shortened Medicaid application, linked to a physician, with initial care cost defrayed by Title V, etc., if they do not have health care financing.
Pregnancy testing and verification required for Medicaid eligibility is provided at no charge to women, without regard to income. All medical providers and all local Department of Health and Human Resources offices have been visited to remind them of the above OMCFH policy; that is, OMCFH will pay for the initial prenatal visit and all initial out-patient lab without benefit of any financial declaration for any medically indigent women.
The OMCFH also works in concert with the Divisions of Primary Care and Recruitment to develop capacity specific to the professional shortages; i.e., obstetrics.

c. Plan for the Coming Year

West Virginia has done a good job of getting their pregnant women into early care. The Perinatal Program, Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The project provides the following services: 1) Recruitment of medical practitioners to care for low income, government sponsored populations (Title XIX, Title V). 2) Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national standards. 3) All participating providers complete signed agreements with OMCFH specific to services/benefits, risk scoring and patient information exchanges. 4) Direct financial assistance for obstetrical care for pregnant adolescents ages 19 and under who are not eligible for Medicaid. 5) Provides financial assistance for pregnant adolescents ages 19 and under regardless of income. 6)Direct financial assistance for prenatal care for non-citizens. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation). 7) Direct financial assistance for obstetrical care for pregnant women denied Medicaid, with income at or below 185 percent of the Federal Poverty Level. 8) Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are

subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. The services may include lab work, the initial prenatal visit, and ultrasound, if necessary. This was the closest we could come to presumptive eligibility. The cost of these services are paid for by the OMCFH using Title V funds. 9) Assistance for patient access to health care and the WIC Program. Coordination of medical care for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. 10) All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of age appropriate children (ages 6 months to 6 years) screened for blood lead.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	35	35.0	35.0	35.0	35.0
Annual Indicator	11.2	9.8	10.8	9.8	9.9
Numerator	8913	11038	12176	12071	12180
Denominator	79607	112916	112916	122916	122916
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35.0	35	35	35	35

Notes - 2002

data source: OMCFH, Childhood Lead Poisoning Prevention Program

Notes - 2003

Data used from the Childhood Lead Poisoning Prevention Program.

Notes - 2004

Data from the WV Childhood Lead Poisoning Prevention Project

a. Last Year's Accomplishments

Childhood Lead Poisoning and Prevention Project (CLPPP) and Research, Evaluation and Planning Division staff developed and continued to refine an active surveillance system with all laboratories for mandatory reporting of blood lead testing results to the Office of Maternal, Child and Family Health. These population-based surveillance activities are coordinated with the

EPSDT pediatric field staff as a part of medical provider orientation, monitoring and technical assistance.

The CLPPP provided a strong educational/technical assistance program to elementary schools, and child care service sites, including Head Start and EPSDT providers on a statewide basis, targeting high risk counties. In addition to these efforts, public presentations have occurred at forums made available by local church groups and through parent advisories of agencies responsible for children's health services and/or child care. In 2004, the OMCFH Community Education and Awareness Provider made presentations and provided educational displays at public health fairs reaching at least 2,400 persons, mostly in the high risk areas.

The CLPPP works with local health departments and the Office of Environmental Health Services to implement a community level case management system which relies on both local health department nurses and sanitarians.
The CLPPP investigated the filter-paper specimen submission method which was using a few drops of blood from an already scheduled finger stick making it less painful to collect the sample. Some providers are now using this method.

An agreement was entered into with an area WIC office, serving multiple counties, to use the first two drops of blood, from the already scheduled iron sufficiency test, to test for blood lead levels. This agreement was an effort to screen high risk children targeted in a high risk area.

SB 216 passed in 2002 mandating universal blood lead screening, following CDC protocol, for all children under the age of 6. The legislative rules for the universal lead screening law went in effect in 2004.

The number and percent of children 0 to 72 months of age screened for elevated blood lead levels was the highest in 2002. Children receiving Medicaid benefits had a prevalence rate of 15 per 1000 for elevated blood lead levels, while non-Medicaid eligible children had a prevalence rate of 9 per 1,000.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational presentations delivered at community/ parent meetings in high risk areas.		X		
2. Annual inservices are offered to medical professionals on importance of screening.		X		
3. The CLPPP has a strong relationship with the Office of Environmental Services.		X		
4. The CLPPP offers case management services to children identified with increased blood lead.		X		
5. The CLPPP partners with WIC to increase blood lead screening in a high risk area.		X		
6. An Epidemiological Snapshot is created annually to provide current information to providers.				X
7. Lead Advisory is maintained for operational guidance.				X
8. Medicaid pays for environmental assessments.		X		
9.				

10.

b. Current Activities

According to the 2000 Census, 75.2% of occupied housing units within WV are owned by the occupant, ranking number two in the nation. Also, 41% of all WV housing was built before 1960. Twenty-seven percent of the occupied pre-1960 housing is renter-occupied and 73% is owner occupied, compared to 66% nationally. Because WV is predominantly a rural state, many homes have been passed down from generation to generation and are mortgage free. The older housing is either renovated or not upgraded and maintained and 3% of WV housing lacks complete plumbing.

West Virginia continues to collaborate with the EPSDT Program to screen all children for lead poisoning who are eligible for Medicaid. Information on lead poisoning is distributed through the EPSDT workforce to parents and all medical practitioners serving children. The CLPPP continues to maintain strong relationships with the Division of Environmental Health and local health departments in providing environmental assessments in homes where children with increased blood lead levels live. All children identified with increased blood lead levels > or equal to 10ug/dl are referred to CSHCN. The CLPPP maintains a strong educational component reaching over 2,400 parents, child care workers, care givers, physicians, nurses and social workers through a myriad of presentations and displays. Educational and screening efforts are targeted in higher risk areas and populations.

WV continues an agreement with a higher risk area WIC program to screen for elevated blood lead levels when the child is scheduled for iron deficiency testing. This eliminates the need for an additional finger stick and ensures screening of a high risk population.

Senate Bill Number 216 which passed in January 2002 requiring systematic screening of children for early identification and prevention of lead poisoning in children 0-72 months of age had rules and regulations specific to this legislation passed in the 2004 legislative session.

WV has submitted screening and elimination plans which includes targeting the nine (9) highest counties at risk to screen for blood lead levels. Included in the submitted budget is a plan to train risk assessors to perform housing assessments reaching across the state.

The nurse case manager partnered with Environmental Specialist and conducted home site visits wherein the child is clinically assessed by the RN while the lead specialist actually collects and identifies lead samples and hazards within the home's interior, exterior, water and soil. Both assessments provide valuable data for future medical treatment and/or monitoring and also identifies the lead hazards resulting in removal and/or remediation from the child's living environment. In addition, onsite hands-on approach allows one-on-one education to the childs parent or legal guardian. Onsite assessment promotes outreach resources to assist the wellbeing of the child. From July 2004 to April 2005 there were 29 home visits conducted.

c. Plan for the Coming Year

The overall CLPP Project goal is to decrease the number of new cases of lead poisoning, defined at a level of greater than or equal to 10mcq/dl, to less than one percent of the tested population of children 0 to 6 years of age and to decrease to less than three percent those children in targeted high risk counties. Activities for this coming year will focus on: 1) geographically targeting project activities to the identified nine highest at risk counties for increased screening and prevention efforts, 2) working with the county commissioners in the nine targeted counties to encourage active participation in seeking funds for remediation of homes identified wtih lead hazards that have been harmful to the children living there, 3) increasing the number of lead risk assessor in the nine high risk counties to assist with assessing lead hazards and training parents within their local community on preventive

methods, 4) increasing screening rates in the nine targeted counties and 5) educating teh physician community within the nine targeted counties on the need to screen and test children under the age of six (6) for lead poisoning.

WV continues to have strong support from its Advisory Council and will continue to encourage participation and involvement.

Home lead assessments will continue to be performed as needed and requested.

State Performance Measure 2: *Percent of women >= 18 years of age receiving a Pap smear within the preceding three years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85.0	85.0	85.0	85
Annual Indicator	70.9	82.5	85.2	85.7	86.2
Numerator	438350	510230	526800	530000	533200
Denominator	618527	618527	618527	618527	618527
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	87	87	88	88

Notes - 2002

data source: OMCFH, WV Breast and Cervical Cancer Program

Notes - 2003

Data from the 2002 West Virginia Behavioral Risk Factor Survey Report.

Notes - 2004

Data from the 2003 WV Behavioral Risk Factor Survey Report

a. Last Year's Accomplishments

IN CY 2004, the Family Planning Program provided Pap smears for over 41,000 low-income, uninsured women receiving contraceptive services;
In February 2004, the Family Planning Program released a Policy Update regarding national standards of care for cervical cancer screening. These guidelines reflected American Cancer Society, Bethesda System 2001, and American Society of Colposcopy and Cervical Pathology (ASCCP) recommendations.

During CY 2003, the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) provided 11,130 Pap tests to Program eligible women. Of the 11,130 Pap tests performed by the WVBCCSP, 89.5% were negative for intraepithelial lesion or malegnancy.

Data from the 2002 BRFSS data indicated that 14.1% of women aged 18-24, 8.3% of women aged 25-34, 11.6% of women aged 35-44, 8.5% of women aged 45-54,16.3% of women aged 55-64, and 32.5% of women aged 65+ reported that they had not had a Pap test in the past three years. Program data from July 1, 2003 through December 31, 2003 revealed a never or rarely screened percentage of 22.9%. Never or rarely screened refers to a woman who has never received a Pap test, or who has had a Pap test, but it was five or more years age.

Each January during National Cervical Cancer Awareness Month, the WVBCCSP helps spread the word about cervical cancer and cervical cancer screening to women in West Virginia through education and outreach. One of the major activities conducted during this month are the Free Pap Test Days, where women in need of cervical cancer screening services can receive a free Pap test.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OMCFH houses the Breast and Cervical Cancer Screening Program (BCCSP).				X
2. BCCSP offers education, assessment, outreach, surveillance, case management and follow-up services.		X		
3. Screenings are provided statewide through contractual agreements.		X		
4. Breast and cervical cancer screening and family planning is offered statewide in all 55 counties.		X		
5. WV provides full Medicaid benefits to uninsured women under age 65 identified by the BCCSP, as having cancer of the breast or of the cervix, under the BCCSP Treatment Act.		X		
6. Provided Pap smears to 42,886 low-income, uninsured Family Planning Program clients receiving contraceptive services.		X		
7. BCCSP paid for 11,435 pap smears in FY 2003-2004.		X		
8.				
9.				
10.				

b. Current Activities

Currently, the WVBCCSP is plannig activities to be conducted during National Cervical Cancer Awareness Month (January) to raise awareness and promote cervical cancer screening. Included among these activities are Free Pap Test Days. Free Pap Test Days offer free cervical cancer screening to women in need. Cancer Information Specialists (CIS) organize the event with local health care providers and assist in helping the women receive their screening exams. Women who are eligible for the WVBCCSP are enrolled in the Program with the help of a CIS. Historically, these events have enrolled numerous women into the Program and have provided free Pap tests to women who are never or rarely screened for cervical cancer.

By the close of CY 2004, the Program anticipates providing over 10,500 Program paid Pap tests. The decline in the number of Pap tests performed is due to the implementation of the Centers for Disease Control and Prevention's (CDC) policy on cervical cancer over-screening. In an effort to minimize cervical cancer over-screening, the WVBCCSP is mandated by the CDC to only use federal funds to pay for Pap tests once every three years after a woman has had three, consecutive, normal Pap tests within a 5 year (60 months) period. The WVBCCSP

continues to offer HPV testing for Program enrolled women who have a liquid based Pap test result of ASC-US or negative for intraepethelial lesion or malignancy. Spanish language cervical cancer materials wre distributed to health departments in counties around West Virginia with a high number of Hispanic residents.

c. Plan for the Coming Year

The WVBCCSP will continue to provide quality cervical cancer screening services to its eligible population which includes low income, uninsured, underinsured, older women, minorities, and women who live in rural areas. The Program also places a special focus on never or rarely screened women, women with disabilities, and women who partner with women. The Program estimates that it will provide apporximately 11,000 Pap tests during FY 2005-2006. Complete and timely follow up services and case management will continue to be a key factor in serving West Virginia's eligible population as well as continued public education and outreach activities to increase cervical cancer awareness. To ensure compliance with CDC policies, the WVBCCSP will continue to monitor cervical cancer screening and prohibit over-screening clients. HPV testing will be closely monitored to ensure all women in need of HPV testing receive this service. Any non-compliance will immediately be addressed and corrected. Innovative strategies will continue to be used to reach the never or rarely screened population.

State Performance Measure 3: *Percent of women >= 50 years of age receiving a mammogram within the preceding 2 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75.0	76.0	76.0	86
Annual Indicator	76.4	77.2	85.6	85.8	86.2
Numerator	247540	250112	277306	278100	279250
Denominator	324006	324006	324006	324006	324006
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.3	87	87.5	88	88

Notes - 2002

data source: OMCFH, WV Breast and Cervical Cancer Program

Notes - 2003

Data from the 2002 West Virginia Behavioral Risk Factor Survey Report.

Notes - 2004

Data from the 2003 WV Behavioral Risk Factor Survey Report

a. Last Year's Accomplishments

During CY 2003, the WVBCCSP provided 10,202 screening mammograms and 15,085 clinical breast examinations (CBE). Sixty-three cases of invasive breast cancer were also discovered as a result of screening services provided through WVBCCSP. The 2002 West Virginia Behaviour Risk Survey reported that 20.1% of West Virginia women aged 45-54, 17.2% of women aged 55-64, and 30.7% of women aged 65+ have not had a mammogram in the past two years.

Breat Cancer Awareness Month activities were also conducted during October 2003. Activities for the month included Walks for Women, Think Pink luncheons, wreath hanging ceremonies, breast cancer proclamations, and breast cancer awareness events.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BCCSP offers education, assessment, outreach, surveillance, case management and follow-up services.		X		
2. Breast and cervical cancer screening and referral is offered statewide.		X		
3. WV certifies 90+ mammography sites yearly, as meeting national standards.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current WVBCCSP data for CY 2004 projects that the Program will perform apporximately 10,000 screening mammograms and over 14,000 CBEs by the end of the year. An estimated 51 cases of invasive breast cancer will be diagnosed as a result of screening. The WVBCCSP is offered in all fifty-five counties around the state and currently has a provider network consisting of 165 screening providers performing CBEs, 85 mammography providers, 39 fine needle aspiration providers, and 49 breast surgeons. Breast Cance Awareness Month activities were also conducted in all fify-five counties during October 2004. Spanish language breast cancer materials were distributed to health departments in counties around West Virginia with a high number of Hispanic residents. Breast algorithms were reviewed and revised. The WVBCCSP Program Director is a member of the Susan G. Komen Breast Cancer Foundation Executive Board.

c. Plan for the Coming Year

The WVBCCSP anticipates providing over 15,000 CBEs and over 10,000 mammograms during FY 2005-2006. the Program will continue to provide quality breast cancer screening services to eligible populations of West Virginia women. Case management services and timely follow up will remain an important part of the WVBCCSP. Efforts will continue to be focused on providing mammograms for women aged 50-64. Avenues are also being explored to identifying and obtaining additional funding sources in order to pay for mammograms in women aged 40-49

who are not at high risk for getting breast cancer. Current CDC guidelines do not allow for the use of NBCCEDP funds to pay for mammograms in this population. Breast Cancer Awareness Month activities will continue to be conducted during October 2005.

State Performance Measure 4: *Percent of women with prenatal care paid for by Medicaid receiving first trimester prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	81	87.0	87.0	87.0	88.5
Annual Indicator	81.2	82.4	88.0	78.7	77.9
Numerator	7814	8953	7041	7321	7400
Denominator	9626	10868	7998	9297	9500
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.5	88.6	88.7	88.7	

Notes - 2002

data source: WV Health Statistics Center

Notes - 2003

Statistics from Vital Stats and based upon the number of live births with known onset of prenatal care and known Medicaid recipients. PRAMS data

Notes - 2004

Estimated

a. Last Year's Accomplishments

In CY 2003 88% of all pregnant women in the State received first trimester prenatal care. In CY 2002, a substantially lower proportion, 79%, of women whose prenatal care is being paid for by Medicaid received first trimester prenatal care. Nevertheless, trend data indicate that the proportion of such women has increased steadily over the years. Contributing to this substantial increase is the State's Right From The Start Project (see National Core Performance Measure 18), and free pregnancy testing offered by Family Planning, referenced earlier. In addition to first trimester prenatal care being a factor associated with intendedness of pregnancy, payor source for deliveries is as well. Women who access medical care, but have no source of coverage at the initial visit are referred to OMCFH by the medical community for assistance, including securing health care financing. Also referenced earlier, OMCFH serves as the initial payor for the patient's preliminary care, while exploring all health financing options.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's perinatal program RFTS, provides comprehensive perinatal services to low income pregnant women and infants up to age 1 year.		X		
2. Uninsured adolescents age 19 years and under are automatically eligible regardless of income.		X		
3. The OMCFH ensures information about the need for early and continuous care is provided.			X	
4. Shortened Medicaid eligibility forms improve access to care by expediting coverage.		X		
5. The OMCFH resources pay for the initial visits for any medically indigent women.		X		
6. The OMCFH works with Divisions of Primary Care and Recruitment to develop medical capacity.				X
7. All DHHR local offices have been linked to MCFH toll-free lines for referrals for care.				X
8. RFTS staff provide inservice statewide on eligibility processes.				X
9.				
10.				

b. Current Activities

West Virginia's perinatal program, Right From The Start (RFTS), is administered by the OMCFH. Core components are care coordination and enhanced services to reinforce the positive effect of medical care on the health and well-being of mothers and infants. Increasing access to prenatal and delivery care that meets nationally recognized standards to improve pregnancy outcome is the goal of this program.

RFTS focuses on coordination of medical care for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

RFTS has continued to provide statewide presentations which explain the process of referals into RFTS including health financing (Title XIX and Title V). The Right From The Start Project has developed a Power Point presentation outlining the benefits and protocols of the Project for the purposes of education and to promote RFTS among the local Department's of Health and Human Services staff. The presentation details and clarifies the referral process, eligibility requirements, and the case management services provided to eligible pregnant women and their infants. The presentation is designed to encourage early prenatal/infant referral to RFTS and to increase awareness of the variety of services offered. The RFTS Regional Care Coorinator (RCC) also attends the training sessions and is introduced as the contact person for follow up on referrals or for additional questions. The RCC will then follow up with the obstetrical care providers to refresh their knowledge of the referral process.

In 2003, the RFTS Project has provided this presentation to staff from several county DHHR offices. RFTS presentations for DHHR staff in additional counties were held in 2004. The

presentations have provided RFTS with positive feedback about the Project, provided a forum for policy updates, questions, and answers, and an opportunity for the Regional Care Coordinators to establish rapport or build on their current relationship with local DHHR offices.

c. Plan for the Coming Year

The OMCFH will continue to advocate for Medicaid coverage of pregnant women and continue to support the availability of free pregnancy test sites through Family Planning. OMCFH will continue to support reform in malpractice insurance to assure availability of providers (access). Through the Family Planning Program, with verification of pregnancy, the OMCFH ensures the patient has located a prenatal care provider, and (if medically indigent) has been provided a shortened Medicaid application and an agency referral to WIC.

State Performance Measure 5: *Percent of unintended pregnancies.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	34	34.	34.	34.	34.
Annual Indicator	41.8	41.9	40.3	40.9	41.7
Numerator	7498	7130	6954	7050	7185
Denominator	17949	17002	17246	17246	17246
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	34.	33	33	33	33

Notes - 2002

data source: OMCFH, WV PRAMS

Notes - 2003

Statistics from PRAMS data. PRAMS data for 2002 and 2003 not available yet. 2002 data should be available sometime this summer 2004.

Notes - 2004

Data estimated from PRAMS...2003/2004 data not yet available. PRAMS data comes from a weighted sample.

a. Last Year's Accomplishments

In CY 2004, the Family Planning Program provided comprehensive reproductive health services to 63,658 unduplicated clients, an decrease of approximately .8% from CY 2003. Confidential access to contraceptive services is crucial in helping sexually active teenagers obtain timely medical advice and appropriate medical care to reduce teen pregnancy and STD rates. In CY2004, the Family Planning Program provided confidential contraceptive services to

17,957 teens (17,383 females and 574 males).

In CY 2003, the Family Planning Program continued financial support for female and male sterilization procedures, with 330 female and 121 male procedures, for a total of 451 sterilizations; in FY 2005 sterilization services under Family Planning were discontinued.

In CY 2004, due to funding restrictions, the Family Planning Program was forced to limit the number of sterilization procedures. From 1-1-2004 through 11-15-2004 the Family Planning Program completed 270 female procedures and 73 male procedures, for a total of 343 sterilizations.

Family Planning provider training and staff development courses, sponsored in whole or in part by TRAINING 3 included the following:

"Reproductive Health Update"
April 1, 2004, Charleston, WV (30 participants)
June 30, 2004, Martinsburg, WV (35 participants)

"Working with Minors: Requirements and Implications in a Family Planning Setting"
March 5, 2004, Morgantown, WV (58 participants)
May 14, 2004, Beckley, WV (49 participants)

The U.S. Guide to Clinical Preventive Services identified post-coital administration of emergency contraceptive pills (ECP) after unprotected intercourse as a means of reducing subsequent pregnancy. ECP is estimated to reduce the number of subsequent pregnancies by 75%.

The following is Family Planning Program ECP data for CY 2004:
-ECP Administration: 1,489 visits
-ECP Follow-up: 139 visits
-ECP Advance Prescription: 280 visits
-109 of 140 sites (77.9%) of all FP sites prescrived on site. The remaining 31 sites (22.1%) referred FP clients to another site for administration.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH has a strong Family Planning Program offering free contraceptive care to low income.			X	
2. OMCFH uses PRAMS data to follow the trends and recruits additional health care agencies and private providers for participation in the FP Program.				X
3. Maintain agreements with 145 clinic network providers to deliver statewide Family Planning Program services.		X		
4. The Abstinence Program targets children ages 9-14 to discourage early sexual activity		X		
5. Evaluate cost-effectiveness of new contraceptive methods, alternative contraceptive products and treatment medications.				X
6. Intensive community education and outreach activities for prevention of unintended pregnancies.			X	

7. Providing confidential medical and laboratory services and free contraceptive methods as well as providing client education/counseling on pregnancy/STD prevention and use of contraceptive methods for enrolled clients.		**X**		
8. Provide confidential medical and laboratory services and free contraceptive methods to enrolled clients		**X**		
9. Emergency contraception provided by family planning sites.		**X**		
10.				

b. Current Activities

For FY 2005, the Family Planning Program contracted with one hundred (100) delegate agencies, representing one-hundred forty-five (145) clinic sites for the provision of comprehensive family planning services. Five (5) of these service sites, known as "Special Agreement" clinics, provide family planning services for their enrolled populations, i.e., university/college student health centers and a Job Corps Center.

Client education and counseling on reproductive anatomy/physiology and contraceptive methods is provided in accordance with the Family Planning Program Guidelines, 2001 as evidenced by medical record audits completed by the OMCFH Quality Assurance and Monitoring Team and site reviews conducted by the Family Planning Program Specialists. A targeted emphasis on the requirements for detailed client education and counseling has been reflected in positive audit results which have indicated more thorough documentation of services provided.

c. Plan for the Coming Year

Maintain Memorandum of Understanding with 145 existing delegate agencies/clinics to deliver clinical Family Planning Program services;

Provide client education and counseling on reproductive anatomy/physiology and use of contraceptive methods consistent with Family Planning Program Guidelines, 2001;

Provide confidential medical and laboratory services and contraceptive methods to enrolled clients, consistent with Family Planning Program Guidelines, 2001;

Monitor and evaluate the cost-effectiveness of new contraceptive methods, alternative contraceptive products/formulations and treatment modalities for possible addition to the Family Planning Program formulary;

Provide surgical sterilization services for female and male clients (as funding permits) in accordance with Family Planning Program Guidelines, 2001;

To improve access, recruit additional health care agencies and private providers for participation in the program (as funding permits);

Coordinate STD services in Family Planning clinics with the WV STD Program to assist with client testing, treatment, partner referrals, and Disease Investigation Specialist (DIS) tracking services.

State Performance Measure 6: *The incidence of young women 15-19 years of age who have contracted Chlamydia.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	833	1000	1000	1000	400
Annual Indicator	1.2	1.4	0.8	0.7	1.4
Numerator	801	831	463	446	885
Denominator	69268	61043	61043	61043	61043
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	400	400	400	400	900

Notes - 2002

data source: Epidemiology and Health Promotion; WV Chlamydia Program

Notes - 2003

Data from the Surveillance and Disease Control STD division.

Notes - 2004

Data from the Surveillance and Control STD information.

a. Last Year's Accomplishments

Chlamydia positivity in Family Planning Program clients decreased 0.1% from 2002 to 2003.

The Family Planning Program continued to offer STD counseling, education, screening, diagnosis, and treatment activities. Testing and treatment of chlamydia, gonorrhea, and syphilis are available for established Family Planning clients. In January 2003, the Family Planning Program distributed summaries of 2002 Sexually Transmitted Diseases (STD) Treatment Guidelines, published by the WV Bureau for Public Health, Division of Surveillance and Disease Control and the Centers for Disease Control and Prevention. Providers were encouraged to place the laminated documents in their exam rooms for reference in the treatment of STDs.

Chlamydia Screening, Diagnosis, and Treatment:
Through the Region III Infertility Prevention Project (IPP), 38,564 Chlamydia tests were completed for Family Planning clients in CY 2003, with a 2.2% positivity. In 2003, Chlamydia decreased by 0.1% statewide, as compared to the number of positive reports received in 2002. Approximately 97% of all women in Family Planning clinics diagnosed with Chlamydia received treatment, as confirmed by WV DIS staff.

Participation in Region III Chlamydia Advisory Committee:
In 2003-2004, Stephanie Thorn, Family Planning Specialist, continued active participation in the Region III IPP Advisory Committee, serving as a voting member of the full committee (proxy for Anne Williams), in addition to participation on the Clinical and Program Management Subcommittee.

STD Educational/Training Program:
With changing trends in research and treatment of STDs and HIV, it is important for family planning staff to stay up to date. In cooperation with TRAINING 3 and the WV STD Program, the Family Planning Program offered a course, "New Developments: Diagnosis, Treatment and Counseling on STDs and HIV" (November 19, 2003, Charleston, WV). This course provided Family Planning staff with new information about the most common STDs likely to be encountered in the clinic setting, as well as HIV. Participants were informed of local resources available to clients diagnosed with STD and HIV. Speakers for the course included Dr. Anne Rompalo, Associate Professor of John Hopkins University School of Medicine; Terry Hogan, Director of Region III STD/HIV Prevention Training Center, and Greg Moore, Assistant Director of the WV STD/HIV/AIDS Program

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Program monitors the incidence of chlamydia.			X	
2. The Family Planning Program provides chlamydia tests for females ages 15-19.		X		
3. Women in Family Planning clinics receive risk reduction counseling relative to chlamydia.		X		
4. All Family Planning Program clients with positive results are treated free of charge.	X			
5. Family Planning staff serve on the Region III Infertility Prevention Project Advisory Committee.				X
6. Provide STD counseling/education, testing and treatment services in 145 Family Planning Program clinics.		X		
7. Work with STD Program to enhance partner referrals and Disease Investigative Specialist (DIS) tracking services.				X
8. Work with STD Program to revise WV Chlamydia Screening Protocols age parameters from <30 yrs to <25 yrs.				X
9. Work with STD Program on urine-based Chlamydia Screening project targeted to high-risk male populations.				X
10.				

b. Current Activities

Male Expansion Project:
The Family Planning Program continues to work with the WV Sexually Transmitted Disease Program in the Region III Infertility Prevention Project (IPP) Male Services Expansion (2002-2005). Given the problem of reinfection in women and factors involved in not reaching males, a Male Demonstration Project has been on-going throughout 2002-2005 in juvenile detention centers, school based health centers, and selected Special Agreement sites. The APTIMA Combo II Assay (the urine test for Chlamydia) has been used to determine positivity for asymptomatic men. Three thousand (3000) men will be tested, with possible changes in test technology or equipment resulting from this Demonstration Project. Upon completion and following data review, results may indicate a need for urine-based Chlamydia screening in all FP and STD clinics;

Coordination with WV STD Program:
The Family Planning Program administration works collaboratively with the WV Sexually

Transmitted Disease Program to assure high quality general STD/HIV education and counseling services. The Family Planning and STD Programs worked closely to facilitate STD counseling, screening, and treatment of women not served through the STD clinic system. The Family Planning Program provides initial diagnosis and treatment of STDs; For continuing treatment, partner follow-up, or HIV testing, clients are referred to the STD Program for services. WV STD Program Disease Intervention staff (DIS) also provide partner notification, testing, and treatment services on request from Family Planning clinics.

In 2004, the Family Planning Program completed revisions to the WV Chlamydia Services Protocols.

c. Plan for the Coming Year

Coordinate STD services in FP clinics with the WV STD Program to assist with client testing, treatment, partner referrals, and Disease Investigative Specialist (DIS) tracking services;

Work collaboratively with partners from the STD Program, WV Office of Laboratory Services and the Region III Infertility Prevention Project to evaluate and update the WV Chlamydia Screening Protocols;

Collaborate with STD Program to consider modification of WV Chlamydia Screening Protocols to rescreen positive clients 4-6 months post treatment, in accordance with CDC STD Treatment Guidelines, 2002;

Collaborate with STD Programs to consider modification of WV Chlamydia Screening Protocols to revise age parameters for screening criteria (change from <30 years of age to <25 years of age);

Participate in WV STD Program urine-based Chlmydia screening project targeted to high-risk male population (juvenile detention centers, prisons, special agreement sites) to distribute FP Program brochures, clinic directories and materials.

State Performance Measure 7: *The percent of women not smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	78	78.0	78.0	79.0	79.0
Annual Indicator	74.0	73.9	73.8	73.6	74.7
Numerator	15436	13264	15191	15322	15410
Denominator	20860	17949	20590	20830	20630
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	80.0	80	80	82	82

Notes - 2002

data source: OMCFH, WV PRAMS

Notes - 2003

2002 data from Vital Stats based upon the number of live births with known smoking status, 2003 data provisional.

Notes - 2004

estimated Data from PRAMS...2003/2004 data not available at this time...PRAMS data is from a weighted sample.

a. Last Year's Accomplishments

According to West Virginia Vital Statistics, West Virginia pregnant women smoking rate for 2003 was 26%, U.S. rate was 11%. West Virginia still has the highest smoking rate for pregnant women in the United States. Data from the Birth Score Office shows that many counties in West Virginia have a self-reported rate of between 30 to 57% among Medicaid mothers who smoked during pregnancy. This creates an enormous health problem for West Virginia which impacts not only the developing infant but the pregnant woman, her children, and other exposed family and friends, not to mention the impact on the health care community. Pregnant women participating in the RFTS Project have a high incidence of smoking during pregnancy. To address this issue RFTS has adopted an intense smoking cessation initiative. The program was developed by Dr. Richard Windsor who has successfully implemented the program in Alabama.

The Smoking Cessation Program developed by Dr. Windsor, was implemented in West Virginia in January 2002, through the Office of Maternal, Child, and Family Health. It was incorporated into the RFTS Project and is known as "The West Virginia Right From The Start 'SCRIPT'". The WV RFTS 'SCRIPT' uses the existing home visitation network and protocols already established in the current RFTS Project. RFTS Project services are provided to pregnant women and infants by registered nurses and licensed social workers throughout West Virginia who are known as Designated Care Coordinators (DCCs).

In January 2002, specific areas of West Virginia were chosen to participate in two Natural History Studies based on the largest concentration of pregnant smokers. The purpose of the studies were to document the number of new Medicaid obstetrical patients who were smokers, to biochemically confirm self-reported smoking status, to establish the natural quit rate during pregnancy, and to document the relapse rate of women reporting they had quit on their own since becoming pregnant. Natural History Study Number One was conducted in six of the eight RFTS regions in West Virginia. One hundred seventy-four (174) pregnant women were enrolled in Study Number One and approximately 74 (42.8%) of these women were self-reported smokers. In the West Virginia counties who participated in Natural History Study Number One, data suggested that self-reported smoking rates among pregnant women ranged from 25 to 58.8%.

WV PRAMS data reported that the prevalence of smoking during the last 3 months of pregnancy was 25.28% in 2002.

2003 RFTS data shows that the 4 top risk factors identified on the PRSI are: 1) partner smokes, 2) patient smokes, 3) partner drinks alcohol an 4) lack of transportation.

2003 data from the WV Tobacco Quit Line indicate 9,878 utilizers, of which 147 were pregnant women. This number has increased yearly from 68 in 2000, 104 in 2001 and 126 in 2002.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program developed by Dr. Richard Windsor in January, 2002 and is ongoing. (SCRIPT)				X
2. The WV 'SCRIPT' uses the existing home visitation network and protocols in the RFTS Project.		X		
3. The effects of smoking during pregnancy are distributed to all women in the OMCFH programs.			X	
4. SCRIPT mandated to be provided to all RFTS/HAPI participants.				X
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. All pregnant RFTS smokers/former smokers are offered CO Testing.		X		
7. State government maintains Quit Line.		X		
8.				
9.				
10.				

b. Current Activities

Natural History Study Number Two was conducted in the summer of 2002 and provided pregnant smokers with interventions which were new to the RFTS Project. The interventions are those currently recognized as best practice methods and are advised for use in tobacco dependence treatment. These new interventions are the use of the 5 A's which are Ask, Advise, Assess, Assist, and Arrange. The RFTS DCCs provided education and support to pregnant smokers who desired to quit using the 5 A's along with the educational patient handbook, "A Pregnant Woman's Guide to Quit Smoking", and the video "Commit To Quit During Pregnancy and Beyond." The pregnant smokers were tested initially for the level of carbon monoxide(CO) in their body by the use of a breathalyzer on the first home visit by the RFTS DCC. After the initial test, they were tested again approximately 4 weeks later following the tobacco dependence treatment education process. Patients could also be tested as often as they requested during that time period. The training for these new interventions was provided to all RFTS staff statewide in March of 2002 by Dr. Richard Windsor and the West Virginia OMCFH Perinatal Services Director, Jeannie Clark. A final document of the results of the "Formative Evaluation of the WV RFTS SCRIPT' has been developed by Dr. Windsor and includes analysis of data gathered during the Natural History studies. These studies collected data regarding the prevalence of smoking among WV pregnant women and the effects of the newly implemented interventions among the study participants. Initial data collected in the Natural History Studies suggested, through the use of carbon monoxide (CO) testing of the pregnant smokers, that the smoking rate among WV RFTS study participants may be as high as 46%.

c. Plan for the Coming Year

The WV RFTS 'SCRIPT' Program is now up and running statewide and includes all regions of West Virginia. Educational tools such as videos, CO monitors, smoking cessation guides, and smoking cessation tools are available to the RFTS DCCs for use in the smoking cessation effort. All of the RFTS DCCs have received training in the tobacco dependence effort to provide pregnant women with best practice smoking cessation methods. Additional training is ongoing

for DCCs and training is continually updated so that all providers are competent to provide best practice tobacco dependence treatment to participating pregnant smokers. RFTS Regional Care Coordinators are now beginning to provide 'SCRIPT' education to other prenatal care providers who are contracted to provide obstetrical services through the OMCFH.

Of great concern to the RFTS Project staff is the fact that the majority of pregnant smokers who successfully stop smoking during pregnancy relapse in the immediate postpartum period. The RFTS Project sees the need to more aggressively address this issue in the future. Addressing this issue is critical in order to prevent long term maternal health complications and prevent second hand smoke exposure among infants. Since the pregnant woman is covered by the RFTS Project and eligible for services for only sixty (60) days postpartum, this issue presents a major challenge to the RFTS DCCs.

Data is now being collected through the OMCFH on all pregnant smokers who are participating in the RFTS Project. Revisions have been completed to the database which now provides more accurate data collection for the project. The goal of the RFTS Project is to see a reduction in the rate of pregnant smokers in the State due to the efforts of the ‘SCRIPT' Program. Through funding provided by the Tobacco Prevention grant, educational materials and curriculum have been obtained which have been proven to be effective in assisting with smoking cessation through research and are considered best practice methods. Through the implementation of these tobacco dependence treatment initiatives, the overall health of individuals, families and infants can be improved, and West Virginia can see a reduction in poor pregnancy outcomes, infant mortality, prematurity and low birth weight rates.

The RFTS Project needs to continue to focus on empowering pregnant participants and their families through support and education so that they feel they can quit smoking.

State Performance Measure 8: *The percentage of eligible children receiving EPSDT services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	50	50.	51.0	51.5	52.0
Annual Indicator	49.8	50.7	50.7	49.9	50.0
Numerator	79972	81292	86941	89586	89650
Denominator	160465	160228	171347	179377	179377
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52.5	53	53	53	53.5

Notes - 2002

data source: HCFA 416, Medicaid/Vital Statistics

Notes - 2003

Data from Medicaid FY 2002 and 2003, CMS-416 report.

Notes - 2004

Estimated

a. Last Year's Accomplishments

HealthCheck is West Virginia's name for the mandated pediatric Medicaid program, Early and Periodic screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in West Virginia have been eligible to participate in the HealthCheck program for the past four years. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exams free of charge.

All families of Medicaid beneficiaries who are children, receive a letter advising them of the EPSDT services and available practitioners.

In FY 2003 and FY 2004, EPSDT utilization was at 50%. EPSDT Family Outreach Workers, located in nine regions of the State inform parents and care-takers of Medicaid eligible children about EPSDT services and encourage them to use the EPSDT services for preventive health. A Program Specialist is assigned to each region and provides recruitment and orientation of new EPSDT providers, and provides technical assistance, orientation of new staff members, an Annual Review of all EPSDT program requirements, and a minimum of two site visits each fiscal year for all existing EPSDT providers.

A written survey of HealthCheck providers was conducted in calendar year 2002. The survey revealed that 90% of the providers who responded to the survey rated the services provided by the Program Specialists as either very effective or effective. Thirty (30) School-Based Health Centers located throughout the State provide EPSDT services at various elementary schools, middle schools, and high schools maximizing site resources.

A new Provider Manual was issued in June, 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. EPSDT works with the Office of Social Services to ensure foster care children receive care.		X		
2. EPSDT Outreach Workers inform parents and caretakers of EPSDT services and encourage use by phone and letter contact.		X		
3. Thirty School Based Health Centers provide EPSDT services.		X		
4. All Medicaid eligible children receive EPSDT outreach and information.		X		
5. A network of trained medical practitioners is in place to provide EPSDT.				X
6.				
7.				
8.				
9.				

10.				

b. Current Activities

The EPSDT Program has an extensive outreach component responsible for meeting federal EPSDT informing, linking and follow-up requirements. Program Specialists and Family Outreach Workers (FOW) are assigned to each region and county to accomplish the outreach activities. An array of services are provided to Medicaid-approved clients by the HealthCheck Program including: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) immunizations; 5) hearing services; 6) laboratory tests; 7) treatment for any health problems discovered during the exams; 8) referrals to other medical specialists for treatment; 9) a check of the child's growth and development; 10) follow-up checkups; 11) health education and guidance; and 12) documentation of medical history. The EPSDT program staff partner and work closely with the Office of Social Services assuring that the 3,000 children who are in state custody, receive EPSDT screens within thirty (30) days of placement. These children receive initial health assessments by medical practitioners especially trained to service at risk populations.

c. Plan for the Coming Year

The EPSDT Program will continue to be operated by the OMCFH through a contractual arrangement with the Bureau of Medical Services and renegotiated every year. EPSDT has contracted with the Health Maintenance Organizations (HMO) to provide outreach services for their child beneficiaries to encourage their participation in EPSDT. EPSDT providers plan to continue offering EPSDT services in the School Based Health Centers as a way to be more accessible and useful for those children who may not otherwise receive services due to restricted access.

EPSDT has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community often lacks capacity in some areas of the state.

E. OTHER PROGRAM ACTIVITIES

The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreement. The exception to this format is Children Special Health Care Needs, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred, as a result of the birth defect registry, birth score, blood lead testing, newborn hearing screening and metabolic screening. It is also important to note that the State's universal risk scoring of infants, called birth score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the MCFH administered Birth to Three Program/Part C IDEA. In addition, MCFH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff who serve as technical resources to the medical community.

All children assessed by CSHCN receive evaluation and case management services to facilitate access to alternative systems of care. All children enrolled in CSHCN, Birth to Three (Part C IDEA), or even our perinatal RFTS program receive case management and care coordination. Children participating in Special Health Care Needs Program access Medicaid, at a rate of 78.6%. This high percentage is attributed to CSHCN commitment to assist families with SSI applications, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group.

The Office supports the Birth Score Project and Genetics Program administered by West Virginia University, Department of Pediatrics. The support for these programs are at the heart of building capacity for the system of care by providing preconceptual counseling; assessment and support for persons with congenital anomalies' and operating a population-wide surveillance system designed to identify infants at possible risk of post-neonatal death (birth score, which includes newborn hearing screening).

Primary preventive health care for the State's children has been historically administered by OMCFH through provider contracts for EPSDT and/or the companion program called Pediatric Health Services (PHS). Pediatric Health Services previously picked up the cost of care for children who had not accessed Medicaid or CHIP. PHS was discontinued as CHIP enrollments became more stable. The PHS did an excellent job of gap filling, and yearly provided payment for 35,000 or more child health visits, and all treatment medications at no cost to the family. Community partners and the MCH population ineligible for Medicaid, were recipients of the OMCFH resource.

The OMCFH continues to provide monies for maintenance of a data repository which keeps current health, social, and community information by county and by type of service statewide. This data repository, linked to OMCFH via modem, is used to access information for client specific questions, received on the OMCFH toll-free lines. As previously discussed, OMCFH has well used toll-free lines which are monitored by independent reviewers. All calls, unless client refuses, are followed up by letter. We also maintain resource information on a variety of topics enabling us to respond to specific concerns. OMCFH program information is also available via Web access with multiple links to access informational guidance on a variety of topics.

Care management and care coordination is provided through established systems, with program specific protocols for each targeted population. In RFTS, social workers and registered nurses involve parents in discussion of family planning, and assist clients who are economically disadvantaged in accessing health care. Our cadre of community-based family outreach workers (FOW's) encourage families to participate in preventive, primary health care for their children.

F. TECHNICAL ASSISTANCE

West Virginia would like technical assistance to examine our systems and identify strategies to positively impact the low birthweight incidence. There were a total of 1,814 low birthweight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2003, representing 8.7% of all births. Of the 1,797 low birthweight infants with known gestational age, 1,253 or 69.7% were preterm babies born before 37 weeks of gestation. (Of all 2003 resident births with a known gestational, 11.7% were preterm babies.) Over one-fourth of the births was to a mother who smoked during her pregnancy. Over the years smoking mothers while pregnant has increased as well. Interestingly enough, infants born to mothers who received 1st trimester care was above the national average and continued to increase. Nearly eighty-six percent (85.8%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 84.3% of mothers nationwide. West Virginia has a strong prenatal program and has implemented the smoking cessation program developed by Richard Windsor with the goal of reducing the number of pregnant women who smoke. With one of the highest smoking rates in the nation for smoking pregnant women and our low birthweight continuing to rise,

V. BUDGET NARRATIVE

A. EXPENDITURES

Please reference notes contained with forms 3, 4 and 5 for a dicussion of budgeted estimates and actual expenditures.

B. BUDGET

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Title X Family Planning; Title XV Breast and Cervical Cancer Screening Program; Part C DEA; Childhood Lead Prevention Program, CDC funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; and PRAMS, funded by CDC. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, Title V has moved away from the sole focus of purchasing or providing indiviudal health services and has placed most of our attention and fiscal resources on developing a system of care. For example, because the state had high incidences of neural tube defect and other congenital anomalies, the OMCFH approached the WVU School of Medicine to develop satellite clinics providing genetics counseling and screening. Although the medical expertise came from the WVU School of Medicine, the funding to make these services more accessible throughout the state came from Title V. These clinics serve everyone, not just persons who have government sponsored health care.

Because WV has a median income of $27,000 for a family of four, the need for services has been great but our resources have been limited. The State Legislature routinely supports Maternal and Child Health, but over the years this commitment has not kept pace with the demand for services and escalating cost. This is largely attributable to the fact that as Medicaid expansions occurred and the CHIP program was introduced, there was an assumption by members of the State Legislature that Maternal and Child Health would not need as many resources. We have attempted to educate the Legislature explaining to them that while these alternate health financing strategies have come into being, the MCH monies are needed to improve the quality of services rendered and improve the availability of care. Like states across the country, WV does not have enough money to fund all the many things that we would like to have for our citizens. For example, several years ago newborn hearing screening legisaltion was passed but there was no accompanying state appropriation. What was obvious to us was that while there was a commitment to identify children who needed intervention, be it hearing aids or whatever, there was no consideration given to the fact that there has to be a mechanism for identifying the children, tracking the children, and making sure the intervention occurred, all of which costs money. OMCFH staff argued this to no avail, so we were very pleased to be a recipient of the Title V monies to support this project. It is true that Medicaid and some insurers would offset the cost of the newborn hearing screening services, but there was no way to individually bill and recover monies necessary for the population-based tracking and surveillance that was necessary...no insurances or Medicaid pay for this activity.

In order to be good stewards of the system, the OMCFH provides leadership for much of the health care services provided in the state. Medicaid, CHIP and others are purchasers, but the OMCFH and its staff recruit the clinicians, establish the care protocols, monitor provider behavior, offer skill building opportunities, etc. all using the resources identified above to improve WV's health care system.

The WV OMCFH adminsiters EPSDT on behalf of Medicaid and has done so for approximately 30 years. The Medicaid Bureau supports the program by paying for the individual health services that the children access. The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the participating providers. We also are responsible for bringing together members of the medical community to provide guidance as it relates to child health, not just EPSDT, but Newborn Hearing, Children with Special Health Care Needs, Birth Defects, Lead, etc. We use many of the programs cited to identify children who are ultimately referrred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serve children who have diagnosed chronic and debilitating conditions but provides free assessment for children referred by their primary care/medical

home. To be sure that we are meeting the demand and have an opportunity for early identification of children with chronic or debilitating conditions, we are offering assessment clinics in our most rural parts of the state. All of these efforts are our commitment to primary and preventive care of the state's children and ultimately have a tie-in to CSHCN when indicated.

Using the statutory authority under Title V that allowed for cost based reimbursement for Medicaid beneficiaries and the authority invested in Title V to be responsible for all populations, we embarked upon an ambitous redesign plan for our Birth to Three/Part C system. This redesign has allowed the State of WV to implement a system change that is more in keeping with tenents of Part C and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay but the many programs administered by the Office serves as a referral conduit. Referral sources include the Birth Score screening that is completed on every baby born in WV to screen for developmental delay or identify those at risk of post neonatal death; our Birth Defects Surveillance System, Metabolic and Newborn Hearing Screening programs, and of course EPSDT. This system change has been in the process for about four years and has resulted in families having an opportunity to select a provider of service, improved financing for the system, and assurance that families are served by appropriately credentialed personnel. We have used Title V connections and fiscal resources to secure support from the medical community including developing physician training programs, offering skill building around the early detection of develomental delay, and to champion messages to their colleagues that the early identification of children who are at risk are important to us all.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.